Issue Date: 26 September 2003 **U.S. Department of Labor**

Office of Administrative Law Judges

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Case No. 2002-BLA-0079

In the Matter of:
ROY FARMER,
Claimant,

v.

NEW HARLAN BLOCK COAL, INCORPORATED,
Employer No. 1,
and
OLD REPUBLIC INSURANCE COMPANY,
Carrier No. 1,

and
BOB & TOM COAL COMPANY,
Employer No. 2,
and
KENTUCKY COAL PRODUCERS
SELF-INSURANCE FUND,
Carrier No. 2,

and
DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-in-Interest.

APPEARANCES:
Sidney Douglass, Esq.
On behalf of Claimant

Stacy Huff, Esq.
On behalf of Employer No. 1/Carrier No. 1

Rodney Buttermore, Esq.
On behalf of Employer No. 2/Carrier No. 2

BEFORE: THOMAS F. PHALEN, JR.

Administrative Law Judge

DECISION AND ORDER – DENIAL OF BENEFITS

This is a decision and order arising out of a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977, 30 U.S.C. §§ 901-962, ("the Act") and the regulations thereunder, located in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.[1]

On November 19, 2001, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs, for a hearing. (DX 48).[2] A formal hearing on this matter was conducted on January 21, 2003, in Benham, Kentucky by the undersigned Administrative Law Judge. All parties were afforded the opportunity to call and to examine and cross examine witnesses, and to present evidence, as provided in the Act and the above referenced regulations.

ISSUES

The issues in this case are:

1. Whether the claim was timely filed;

1. Whether the person upon whose disability the claim is based is a miner;

2. Whether the miner worked after December 31, 1969;

3. Whether the miner worked at least 12 years in or around one or more coal mines;

4. Whether the miner has pneumoconiosis as defined by the Act;

5. Whether the miner's pneumoconiosis arose out of coal mine employment;

6. Whether the miner is totally disabled;

7. Whether the miner's disability is due to pneumoconiosis;
8. Whether the miner has two dependents for the purposes of augmentation;

[1]The Department of Labor amended the regulations implementing the Federal Coal Mine Health and Safety Act of 1969, as amended. These regulations became effective on January 19, 2001, and are found at 65 Fed. Reg. 80, 045-80,107 (2000)(to be codified at 20 C.F.R. Parts 718, 722, 725 and 726). On August 9, 2001, the United States District Court for the District of Columbia issued a Memorandum and Order upholding the validity of the new regulations. All citations to the regulations, unless otherwise noted, refer to the amended regulations.

[2]In this Decision, "DX" refers to the Director's Exhibits, "EX" refers to the Employer's Exhibits, "CX" refers to the Claimant's Exhibits, and "Tr" refers to the official transcript of this proceeding.

9. Whether the named employer is the responsible operator;
10. Whether the named employer has secured the payment of benefits; and

11. Whether the evidence establishes a material change in conditions under § 725.309(d).

(DX 48). The issues of whether the miner's most recent period of cumulative employment of not less than one year was with the named responsible operator, whether the regulations are Constitutional, whether the responsible operator is liable for medical and legal expenses, the unavailability of comparable work, and whether the medical tests meet regulatory standards were raised for appellate purposes.

Based upon a thorough analysis of the entire record in this case, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background

Roy Farmer, Jr. ("Claimant") was born on April 28, 1958 and was forty-four years old at the time of the hearing. (DX 1). On February 23, 1981, he married Debra Sue (Goldsberry) Farmer. (DX 12). Mrs. Farmer gave birth to Amanda Farmer on October 21, 1981 and Joshua Farmer on March 1, 1985. (DX 13). I find that Mrs. Farmer is Claimant's spouse for purposes of augmentation under § 725.204, and that she is a dependent under § 725.205. Similarly, the evidence establishes that Amanda and Joshua Farmer are children of Claimant, but there is no evidence to determine that they are dependent upon Claimant, such as whether or not the children are students. Thus, for the purposes of augmentation, I find that Claimant has one dependent.

Claimant testified that he left high school after the ninth or tenth grade to work for a lumber company. (Tr. 17). He did obtain his GED. (Tr. 17). After his coal mine employment ended in 1994, Claimant worked for as a carpenter for a while. (Tr. 38). He was unable to continue as a carpenter due to problems with breathing saw dust. (Tr. 39). He then drove a school bus for a few months. (Tr. 40).

Procedural History

Claimant filed his initial application for benefits under the Act on February 20, 1996. (DX 47). On August 1, 1996, a claims examiner for the Office of Workers' Compensation Programs ("OWCP") issued a determination that Claimant was not entitled to benefits. The claims examiner found that Claimant established the existence of pneumoconiosis, but denied benefits after finding that the evidence did not show that Claimant's pneumoconiosis arose out of coal mine employment and because the evidence did not show that Claimant was totally disabled by pneumoconiosis. (DX 47). There is no evidence that Claimant sought review of this denial,

and a memorandum to file prepared by the OWCP notes that the claim filed by Claimant on February 20, 1996 is administratively closed and not subject to adjudication. (DX 48).

On November 3, 2000, Claimant filed a second claim for benefits under the Act. (DX 1). He marked the box indicating that he had never filed a claim for Federal Black Lung benefits before. (DX 1). A claims examiner issued letter to Claimant on January 31, 2001 informing Claimant that his duplicate claim was denied because the evidence did not establish that Claimant's pneumoconiosis arose out of coal mine employment and because it did not show that Claimant was totally disabled by pneumoconiosis. (DX 17). Counsel for Claimant, under a cover letter dated February 1, 2001, submitted medical evidence on behalf of Claimant. (DX 18). Apparently the OWCP treated Claimant's February 1, 2001 letter as an appeal. (DX 19). The OWCP deferred reconsideration of Claimant's appeal for ninety days to allow for the submission of additional medical evidence. (DX 19). The OWCP issued a letter on June 7, 2001 finding that Claimant did not establish a material change in conditions. (DX 43). The OWCP also stated that the medical evidence did not establish that Claimant was totally disabled by pneumoconiosis caused at least in part by his coal mine employment. (DX 43). Claimant filed additional medical evidence on August 6, 2001. (DX 45). On November 19, 2001, the District Director, OWCP transferred the claim to the Office of the Administrative Law Judges for a formal hearing. (DX 48).

Timeliness

Claims for benefits under the Act are accorded a statutory presumption of timeliness. § 718.308(c). A claim is timely filed if it was filed before three years after a "medical determination of total disability due to pneumoconiosis" is communicated to the miner. § 718.308(a); 30 U.S.C. § 932(f). Appellate jurisdiction lies with the Sixth Circuit Court of Appeals since Claimant last engaged in coal mine employment in Kentucky. *See Shupe v. Director, OWCP*, 12 B.L.R. 1-200 (1989)(en banc). The Sixth Circuit has issued three relevant decisions on the application of § 718.308.

In *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994), the Sixth Circuit held that the time period in which a miner must file for benefits, under § 718.308(a), starts after each denial of a previous claim, provided that the miner works in the coal mines for a substantial period of time after the denial and a new medical opinion of total disability due to pneumoconiosis is communicated. *Ross*, 42 F.3d at 996. Ross, the claimant, was initially denied benefits under the Act in 1981. He began working again as a coal miner before quitting in 1983. He filed a duplicate claim in 1985. Accordingly, the Sixth Circuit found that Ross' claim was timely filed. In *Ross*, the Sixth Circuit explicitly declined to hold that the statute of limitations only applied to the filing of initial claims. *Id.* The Sixth Circuit found it's holding to be dictated by the progressive nature of pneumoconiosis and logic, since it would make no sense to allow serial applications for benefits and then limit the ability to file serial applications to three years. *Id.*

Five years later, the Sixth Circuit again addressed the application of § 718.308 in *Tennessee Consolidated Coal Co. v. Kirk*, 264 F.3d 602 (6th Cir. 2001). Beginning in 1979, Kirk filed three claims for benefits, all of which were denied. *Kirk*, 264 F.3d at 604. He filed his

fourth duplicate claim in 1992, and was awarded benefits. *Id.* The Sixth Circuit found that Kirk's 1992 claim was timely filed, stating:

> [t]he three-year statute of limitations clock begins to tick the first time that a miner is told by a physician that he is totally disabled by pneumoconiosis. This clock is not stopped by the resolution of the miner's claim or claims, and, pursuant to *Sharondale*, the clock may only be turned back if the miner returns to the mines after a denial of benefits. There is thus a distinction between premature claims that are unsupported by a medical determination, like Kirk's 1979, 1985, and 1988 claims, and those claims that come with or acquire such support. Medically supported claims, even if ultimately deemed "premature" because the weight of the evidence does not support the elements of the miner's claim, are effective to begin the statutory period.

Id. at 608. The Sixth Circuit stated that Kirk's three prior denials do not trigger the statute of limitations because they were premature filings, noting that previous medical opinions did not conclusively opine that Kirk was totally disabled due to pneumoconiosis. Then the Court referenced its unpublished decision in *Clark v. Karst-Robbins Coal Co.*, No. 93-4173, 1994 WL 709288 (6th Cir. 1994), where it rejected a successful state workers' compensation claim that relied upon a finding that the claimant became permanently and totally disabled as the result of the occupational disease of pneumoconiosis as a "medical determination."

The Sixth Circuit addressed the timeliness issue most recently and definitively in reaching their unpublished decision in *Peabody Coal Co. v. Director, OWCP [Dukes]*, 48 Fed.Appx. 140, 2002 WL 31205502 (6th Cir. October 2, 2002)(unpublished). Between 1987 and 1988, Dukes received several opinions from physicians that he was suffering from pneumoconiosis. He filed a claim for benefits under the Act in 1988, which was denied by a Department of Labor claims examiner. Dukes did not appeal and he never returned to coal mining. In 1995 he filed a duplicate claim for benefits, and he was awarded benefits. The Sixth Circuit engaged in a thorough and complete analysis of the three-year statute of limitations, wherein they characterized their holding in *Kirk* as a finding that no "medical determination" exists absent a valid medical opinion, notwithstanding prior knowledge or existence of the disease. *Dukes*, 48 Fed.Appx. at 144. They then held, relying on *Kirk* and paying deference to the remedial intent of Congress in creating the Act, that the three-year statute of limitations applies to subsequent claims. *Id.* at 145. Next, the Sixth Circuit stated that the three-year statute of limitations is not triggered by undiagnosed cases of pneumoconiosis, self-diagnosed cases, and (relying on *Ross*) "all situations in which the miner has filed a claim but has not yet contracted the disease - including claims filed on the basis of a misdiagnosis." *Id.* In light of the denial of Dukes' 1988 claim, the Sixth Circuit found, for legal purposes, that Duke's condition was misdiagnosed. The Sixth Circuit then agreed with and adopted the reasoning behind the Tenth Circuit Court of Appeals' decision that a "final finding by an Office of Workers' Compensation Program adjudicator that the claimant is not totally disabled due to pneumoconiosis repudiates any earlier medical determination to the contrary and renders prior medical advice to the contrary ineffective to trigger the running of the statute of limitations." *Id.*, citing to *Wyoming Fuel Co. v. Director, OWCP [Brandolino]*, 90 F.3d 1502, 1507 (10th Cir.

1996). The Sixth Circuit stated that a misdiagnosis does not equate to a medical determination. *Dukes*, 48 Fed.Appx. at 146. In a restatement of it's holding, the Sixth Circuit stated, "if a miner's claim is ultimately rejected on the basis that he does not have the disease, this finding necessarily renders any prior medical opinion to the contrary invalid, and the miner is handed a clean slate for statute of limitations purposes." *Id.* Effectively, a "proper medical determination" is required to trigger the statute of limitations. *Id*. This holding complies with the recognition of pneumoconiosis as a progressive disease.

After the Sixth Circuit found that a misdiagnosis does not trigger the statute of limitations, it addressed the apparent conflict with its holding in *Kirk*.

In *Kirk*, we stated in dicta that:

> Medically supported claims, even if ultimately deemed "premature" because the weight of the evidence does not support the elements of the miner's claim, are effective to begin the statutory period. Three years after such a determination, a miner who has not subsequently worked in the mines will be unable to file any further claims against his employer, although, of course, he may continue to pursue pending claims.
>
> However, we decided *Kirk* on the basis that the miner there did not have a medically supported claim. Today, we have carefully considered this issue and hold otherwise.

Id.

Claimant's initial claim was finally denied on August 1, 1996, repudiating communication of medical opinions to Claimant that he was totally disabled due to pneumoconiosis arising out of coal mine employment prior to August 1, 1996 for purposes of determining the timeliness of Claimant's duplicate filing. A review of the medical evidence contained in the record indicates that the first communication to Claimant from a physician that he was totally disabled due to pneumoconiosis arising out of coal mine employment after the August 1, 1996 denial of benefits did not occur until September 1, 1999 by Dr. Premji. Since Claimant filed his duplicate claim on February 20, 2000, his claim was timely filed under § 718.308(a) and 30 U.S.C. § 932(f).

Post-1969 Employment

The evidence of record, including third-party affidavits, wage statements, and Claimant's Social Security Earnings record shows that Claimant engaged in coal mine employment after December 31, 1969.

Length of Coal Mine Employment

Claimant alleges that he engaged in twelve years of coal mine employment. (DX 1, 47). He filed an employment history form with his duplicate application for benefits listing coal mine employment with Bob & Tom Coal Company as an underground miner from August 1981 to October 1986 and with F & D Coal Company/New Harlan Block Coal Company as a night watchman and tipple operator from July 1988 to May 1994. (DX 2). Claimant completed an additional form describing his work for New Harlan Coal Company. (DX 3). He wrote that his job was to look after everything around the mine when he was a night watchman. He would also load coal trucks when they came at night. If there was not enough coal processed to load the trucks, he would operate the tipple until there was enough coal to fill the trucks. He acted as a night watchman seven days per week. When he became a tipple operator, he worked five days a week operating the tipple all day. Claimant adduced the affidavits of Alice Phillips, Sheldon Robinette, and Ivan Robinson, which were all notarized on February 26, 2001, stating that Claimant worked at New Harlan Block Coal Company from 1988 until 1994.[3] (DX 4). The record also contains several W-2 statements. (DX 5). Claimant earned $1,543.75 in 1990 from New Harlan Block, Incorporate. There are W-2 statements from 1982, 1983, 1984, 1985, and 1986 from Bob & Tom Coal Company. Additionally, there is a W-2 statement from Dry Branch Coal Company from 1984.

Claimant answered a questionnaire prepared by the OWCP regarding his duties as a night watchman. (DX 8). He stated that he watched the mines from 3pm to 7am from July of 1988 through May of 1994. He noted that he operated the tipple from 7am to 3pm. Claimant completed another OWCP questionnaire. (DX 9). He wrote that he had a verbal agreement to work five days per week for $100.00 from July of 1988 until July of 1990 when he was placed on the payroll. He stated that he was a night watchman from 3pm to 7am and a tipple operator from 7am to 3pm from July of 1988 until May of 1994. Claimant wrote that he did not make enough money to report earnings for income tax purposes until he was placed on the payroll on July 26, 1990. He further noted that he was on New Harlan Company's payroll from July 26, 1990 until May of 1994.

Claimant's Social Security Earnings record documents reported earnings from 1981 through 1986 at Bob & Tom Coal Company and in 1984 from Day Branch Coal Company. (DX 10). The records also show $1,543.75 of earnings in 1990 from New Harlan Block, Inc. in 1990. (DX 10). A statement from Smith Tax & Accounting Services, Inc. confirms that Claimant earned $1,543.75 over the third and fourth quarters of 1990 from New Harlan Block. (EX). The record also contains a settlement agreement entered into between New Harlan Block Coal, Inc. and Special Fund with Claimant. (DX 11). The agreement listed Claimant's date of last exposure as May 1, 1994 and noted that Claimant was exposed to coal dust for 12 years.

On his initial application for benefits, Claimant wrote that he worked in or around a coal preparation facility from 1981 through 1990. (DX 47). He specifically identified his last day of

[3]The affidavits were three identical documents with blank spaces left in the typed text to allow for the affiant to write their name in and the dates that Claimant worked for New Harlan Coal Company.

coal mine employment as October 19, 1990. (DX 47). However, in a document filed in February of 1995 with the Kentucky Board of Workers' Compensation, Claimant wrote that he worked for New Harlan Block Coal from approximately 1990 until approximately May of 1994 loading trucks, operating an endloader, night watchman, and tipple operator. Moreover, he included a reference to working for F & D Coal Company loading coal trucks, operating the tipple and as a night watchman from approximately April 1990 until approximately 1990. On the coal mine employment history form submitted with his initial application, Claimant listed coal mine employment from August 1981 to June 1986 with Bob & Tom Coal and from August 1988 to October 1994 with New Harlan Block Coal Company. (DX 47).

At the hearing, Claimant testified that he began working for New Harlan Block in 1988. (Tr. 22). He testified that he worked there until May 1994. (Tr. 23). Claimant started out as a night watchman and progressed until he was operating the tipple full-time. (Tr. 23). Occasionally as a night watchman, Claimant was required to operate the tipple to process a load or two of coal in order to load the trucks that came in at night. (Tr. 23). He testified that he acted as a night watchman the entire time he worked for New Harlan Block, adding that he worked twenty-four hours a day, seven days per week. (Tr. 24). When he operated the tipple, he worked a ten hour day. (Tr. 24). He was paid $50 a day when he first started, and then he was put on the payroll for twenty hours per week even though he was working forty hours per week. (Tr. 27). Claimant testified that there is no Social Security Earnings record of his employment with New Harlan Block after 1990 because the owner, Freeman Saylor, did not pay Social Security tax. (Tr. 27). He left New Harlan Block in May of 1994 when the tipple was shut down. (Tr. 29). Claimant testified that, after he was put on the payroll, New Harlan Block stopped paying him by check in 1990. (Tr. 30). He stated that he worked for New Harlan Block until 1994 when Freeman Saylor's brother-in-law began to operate the tipple. (Tr. 31). He got into an argument with Freeman Saylor's brother-in-law in May of 1994, which led to him only working as a night watchman for the next few months until the mine was closed. (Tr. 33). As a night watchman, Claimant was loading trucks. He estimated that he began to operate the tipple full-time about one and one-half years after being hired. (Tr. 41). He was paid in cash before working full-time. (Tr. 41).

Claimant also submitted the affidavit of Bill Owens. Mr. Owens stated that he had been a neighbor of Claimant for fifteen years, living across the street from the New Harlan Block coal tipple where Claimant worked from 1988 to 1994. Mr. Owens stated that he saw Claimant operating the tipple and end loader loading coal. He also stated that he remembered Claimant night watching at the tipple also.

Freeman Saylor was deposed post-hearing by the Bob & Tom Coal Company on February 6, 2003. (EX No. 2). Freeman Saylor testified that he was seventy-eight years old and that he had retired from coal mining in 1990 at the age of 65. He was the co-owner of F & D Coal Company, which was formed in 1969. He was the sole-owner of New Harlan Block, Inc., which was formed in 1985. He sold his ownership interests in F & D Coal Company and New Harlan Block, Inc. to his two sons in 1990. Freeman Saylor did not remember very much at all about Claimant.

Freeman Saylor's son, Nicholas Saylor was deposed on February 6, 2003 by Bob & Tom Coal Company. (EX 2). Nicholas testified that he and his brother, Deron Saylor, purchased New Harlan Block from Freeman in January of 1990. Nicholas and Deron operated New Harlan Block until May of 1994, when they pulled all of the equipment out and laid off all of the employees. Initially, he testified that Claimant was employed by New Harlan Block as a tipple operator when he and Deron purchased the company in 1990. Upon further questioning, Nicholas testified that Claimant was not working for New Harlan Block before he and Deron purchased the company and that he did not hire Claimant. Nicholas did not remember Claimant working as a night watchman; Claimant new when to come to work because he lived about one hundred feet from the tipple and he would come over to work whenever a truck arrived. He also remembered paying Claimant by check. Nicholas believes that Claimant quit in October of 1990 when his uncle, Harvey Eldridge, started running the tipple. He specifically testified that Claimant was not employed by New Harlan Block in May of 1994 because that was when the company shut down. Moreover, he testified that Claimant was not on the payroll nor was he paid in cash for any work after the fourth quarter of 1990. Nicholas testified that Deron took care of compensation claims.

Claimant was a coal miner within the meaning of § 402(d) of the Act and § 725.202 of the regulations based on his work as an underground miner for Bob & Tom Coal Company and his work as a tipple operator for New Harlan Block. Claimant has established five cumulative years of coal mine employment with Bob & Tom Coal Company and Dry Branch Coal Company. The evidence surrounding Claimant's employment with New Harlan Block is in conflict. Claimant's account of his work history with New Harlan Coal Company must be discounted based on his inconsistent testimony. At the age of forty-four, Claimant was unable to accurately recall the timeline of his employment with New Harlan Block, even though it allegedly began when he was thirty and ended when he was thirty-six with no significant employment afterwards. Claimant statements on his length of employment with New Harlan Block that varied significantly. Most times Claimant stated that he worked until May of 1994, however, in connection with his initial claim, he made several statements that he only worked for New Harlan Block until October of 1990. He provided several different beginning and ending dates. His testimony at the hearing was inconsistent and sometimes not very credible, including his statements that he worked twenty-four hours per day, seven days a week. What made matters worse was the sloppy manner in which Claimant testimony was obtained on direct and cross-examination. Claimant apparently lived on or near the tipple where he worked for New Harlan Block. He no longer lives there. However, no party questioned Claimant about the time he first parked his mobile home on or near the tipple, nor did any party ask Claimant when he moved his mobile home.

I accord little probative weight to the third-party affidavits submitted by Claimant. Three of the affiants merely wrote in "1988 to 1994", "New Harlan Block", and then they signed their name. The three provided no foundation to indicate their relationship to Claimant, nor did they state how they knew Claimant worked for the years that they stated. Mr. Owens' affidavit provided facts to establish the foundation of his knowledge regarding Claimant's employment. Even though it was not specific regarding beginning and ending dates, I accord probative weight to Bill Owens statement. Similarly, I accord little probative weight to the deposition testimony

of Nicholas and Freeman Saylor. The only definitive fact that Nicholas and Freeman Saylor established was that Freeman Saylor sold New Harlan Block, Inc. to Nicholas and Deron Saylor in January of 1990. Aside from that fact, their testimony was contradictory, incomplete, and inconsistent.

Out of all of the conflicting evidence, there is one scenario that fits with most of the evidence. Claimant noted on several occasions that he began working for New Harlan Block in July or August of 1988. At that time, Freeman Saylor was still the owner of New Harlan Block. Claimant lived near the tipple and began working as a night watchman. Claimant was responsible for letting trucks into the tipple at night. If there was not enough coal processed, he would operate the tipple until the trucks were full. Claimant was likely paid in cash for this work by Freeman Saylor. Claimant recalled that after a year to one-and-one-half years, he was operating the tipple full-time during the day. If he started working for New Harlan in July or August of 1988, that would mean he began operating the tipple full-time during the day around January of 1990. The weight of the evidence establishes that Claimant operated the tipple full-time during the day from January of 1990 until October of 1990. In October of 1990, Claimant was replaced as the tipple operator by Harvey Eldridge. Thus, Claimant worked for New Harlan Block for a period of two years. Out of that two year period, the last ten months were clearly spent working as a miner engaged in the processing of the coal by working at the tipple. The parties reached a settlement agreement in Claimant's Kentucky workers' compensation claim, wherein New Harlan Block, Inc. stipulated that Claimant was last employed on May 1, 1994, which conflicts with New Harlan Block's argument in this matter as well as my finding. However, I am not bound by state agency or Social Security Administration determinations under the doctrine of collateral estoppel. *See Wenanski v. Director, OWCP*, 8 B.L.R. 1-487 (1986); *Freeman United Coal Mining Co. v. Director, OWCP*, 20 F.3d 289 (7th Cir. 1994).

For the first year and two months that Claimant was employed by New Harlan Block he was a night watchman who operated the tipple at night when there was not enough processed coal to load the trucks that arrived. Claimant testified that the amount of time he operated the tipple at night progressively increased until he began operating the tipple during the day. Thus, remaining for determination is whether Claimant's work as a night watchman who operated the tipple progressively more the longer that he worked constitutes coal mine employment.

The Benefits Review Board has established a three-prong test for determining whether a worker is a "miner" within the meaning of the Act. *See Whisman v. Director, OWCP*, 8 B.L.R. 1-96 (1985). The worker must prove that: (1) the coal was still in the course of being processed and was not yet a finished product in the stream of commerce (status); (2) the worker performed a function integral to the coal production process, *i.e.* extraction or preparation, and not one merely ancillary to the delivery and commercial use of processed coal (function); and (3) the work that was performed, occurred in or around a coal mine or coal preparation facility (situs). *Id.* The Fourth and Sixth Circuit Courts of Appeal have generally held that the definition of a Miner is a two-prong, function-situs test. *See Collins v. Director, OWCP*, 795 F.2d 368 (4th Cir. 1986); *Director, OWCP v. Consolidation Coal Co. [Petracca]*, 884 F.2d 485 (6th Cir. 1988).

The function prong requires an individual's work to contribute to the extraction and preparation of coal; a requirement which is satisfied if the individual's activities are found to be an integral or necessary part of the overall extraction process. *See Canonico v. Director, OWCP*, 7 B.L.R. 1-547 (1984); *Bower v. Amigo Smokeless Coal Co.*, 2 B.L.R. 1-729 (1979). Coal is beyond the preparation stage when it is processed and prepared for the market. *Director, OWCP v. Consolidation Coal Co.*, 923 F.2d 38 (4th Cir. 1991).

The situs prong of the test requires that the individual work in or around a coal mine. The Act defines a "coal mine" as:

> [A]n area of land and all structures, facilities, machinery, tools, equipment, shafts, slopes, tunnels, excavations and other property, real or personal, place upon, under or above the surface of such land by any person, used in, or to be used in, or resulting from, the work of extracting in such area bituminous coal, lignite or anthracite from its natural deposits in the earth by any means or method, and in the work of preparing the coal so extracted, and includes custom coal preparation facilities.

Section 725.101(a)(23).

The function of the land, not the individual is important, therefore, the focus of the inquiry is whether the intended use of the area on which the worker is employed is for the extraction or preparation of coal. *McKee v. Director, OWCP*, 2 B.L.R. 1-804 (1980); *Bower v. Amigo Smokeless Coal Co.*, 2 B.L.R. 1-729 (1979). An individual must spend a "significant portion" of their time at a coal mine site to meet the situs test. *Musick v. Norfolk & Western Railway Co.*, 6 B.L.R. 1-862 (1984) (six to eight weekends a year was not a significant portion of the claimant's work time, therefore, claimant was not a coal miner nor a coal transportation worker).

Claimant's work as a night watchman, which satisfies the situs prong, does not constitute coal mine employment because it does not contribute to the extraction or processing of coal. His work operating the tipple and loading trucks at night does constitute coal mine employment; operating the tipple involves the processing of coal that occurs on an area used for the preparation of coal. While the Claimant did not provide a specific accounting of how often he operated the tipple at night over a the first year and two months that he worked for New Harlan Block, the frequency increased until he began operating the tipple full-time during the day. I conclude that Claimant's operated the tipple full-time for ten months and for one year-and-two months at night. Additionally, the parties both agreed that the depositions of Nicholas and Freeman Saylor might be beneficial to clarifying the length of coal mine employment. I credit claimant with one year of coal mine employment. In total, Claimant has established that he engaged in coal mine employment for six years.

Responsible Operator

Liability under the Act is assessed against the most recent operator which meets the requirements of §§ 725.493 and 725.494. The District Director identified New Harlan Block, Inc. as the primary putative responsible operator and Bob & Tom Coal Company as the secondary putative responsible operator. New Harlan Block, Inc. is the employer with whom Claimant spent his last cumulative one year period of coal mine employment and is properly designated as the responsible operator in this case. §725.493(a)(1). Nicholas Freeman testified that he was unsure if New Harlan Block, Inc. was dissolved as a Kentucky Corporation. He also testified that New Harlan Block obtained policies of insurance coverage while it was actively engaged in coal mining from 1990 to 1994. New Harlan Block has not asserted that it is unable to pay, nor has Old Republic Insurance Company denied that it will provide coverage should Claimant be determined to be entitled to benefits. Therefore, based on the record, I find that New Harlan Block, Inc. is capable of assuming liability. *See* § 725.492.

MEDICAL EVIDENCE

The prior denial of benefits occurred on August 1, 1996. Thus, for the purposes of establishing a material change in conditions, only medical evidence developed after August 1, 1996 will be considered.

X-RAY REPORTS

Exhibit	Date of X-ray	Date of Reading	Physician/Qualifications	Interpretation
DX 47	7/26/95	7/26/95	Dahhan, B-reader	negative
DX 47	7/26/95	8/24/95	Powell, BCR, B-reader	0/0
DX 47	7/26/95	4/30/96	Wiot, BCR, B-reader	negative
DX 47	7/26/95	5/14/96	Spitz, BCR, B-reader	negative
DX 47	3/19/96	3/19/96	Baker, B-reader	1/1
DX 47	3/19/96	4/02/96	Sargent, BCR, B-reader	negative
DX 47	3/19/96	4/11/96	Barrett, BCR, B-reader	1/2
CX 1	10/02/00	10/02/00	Tiu	2/1
DX 14	11/27/00	11/27/00	Baker, B-reader	1/1

DX 15	11/27/00	12/9/00	Sargent, BCR[2], B-reader[3]	negative
DX 16	11/27/00	1/03/01	Barrett, BCR, B-reader	1/1
DX 37	11/27/00	3/16/01	Spitz, BCR, B-reader	negative
DX 38	11/27/00	4/12/01	Lockey, B-reader	negative
DX 41	3/01/01	3/01/01	Paranthaman, B-reader	1/0
DX 40	3/01/01	4/24/01	Fino, B-reader	1/1
DX 42	3/01/01	6/29/01	Barrett, BCR, B-reader	1/1
DX 39	3/27/01	3/27/01	Dahhan, B-reader	negative
EX 3	3/27/01	4/23/01	Broudy, B-reader	negative
EX 5	3/27/01	6/28/02	Halbert, BCR, B-reader	negative
EX 7	3/27/01	7/02/02	Kendall, BCR, B-reader	negative
EX 6	3/27/01	7/05/02	Poulos, BCR, B-reader	negative
EX 8	3/27/01	7/16/02	West, BCR, B-reader	negative
EX 2	4/03/01	4/03/01	Lieber, BCR, B-reader	0/1
EX 1	4/27/01	5/16/01	Powell, B-reader	0/1
EX 4	4/27/01	7/02/02	Dahhan, B-reader	negative

On August 17, 1999, Dr. Tiu interpreted a chest x-ray. He found the presence of a fine reticulonodular interstitial process in both lung fields and may represent underlying occupational pneumoconiosis. Dr. Tiu's interpretation on the possible presence of pneumoconiosis is unclassified and ambiguous. His interpretation cannot be relied upon to establish the presence or absence of pneumoconiosis. *See Billings v. Harlan #4 Coal Co.*, BRB No. 94-3724 BLA (June 17, 1997)(en banc)(unpublished).

[2]A physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. *See* 20 C.F.R. § 727.206(b)(2)(III). The qualifications of physicians are a matter of public record at the National Institute of Occupational Safety and Health reviewing facility at Morgantown, West Virginia.

[3]A "B" reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successful completion of an examination conducted by or on behalf of the Department of Health and Human Services. This is a matter of public record at HHS National Institute for Occupational Safety and Health reviewing facility at Morgantown, West Virginia. (42 C.F.R. § 37.5l) Consequently, greater weight is given to a diagnosis by a "B" Reader. *See Blackburn v. Director, OWCP*, 2 B.L.R. 1-153 (1979).

PULMONARY FUNCTION STUDIES

Exhibit/ Date	Co-op./ Undst./ Tracings	Age/ Height	FEV_1	FVC	MVV	FEV_1/ FVC	Qualifying Results
DX 16 11/27/00	Good/ Good/ Yes	42 69"	2.75	3.62	107	75%	No
DX 18 12/4/00	Good/ Good/ Yes	42 70"	2.52	2.66	82	95%	No
DX 41 3/1/01	Fair/ Fair/ Yes	42 68.5"[4]	2.61 2.95*	2.91 3.36*	76 91*	89% 88%*	No No
DX 39 3/27/01	Poor/ Good Yes	42 173 cm	2.85 2.27*	3.48 2.74*	63 71*	82% 83%*	No No
EX 2 4/3/01	/ / Yes	42 69"	2.3	2.77		83%	Patient unable to produce acceptable and reproducible spirometry data; no airways obstruction; restrictive defect secondary to obesity; reduced diffusing capacity - invalid due to poor inspiration

*post-bronchodilator values

ARTERIAL BLOOD GASES

Exhibit	Date	pCO_2	pO_2	Qualifying
DX 16	11/27/00	41 42*	74 90*	No No

[4] I must resolve the height discrepancy recorded on the pulmonary function tests. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). I find that the miner's actual height is 69 inches.

DX 41	3/1/01	38	72	No
DX 39	3/27/01	38.6 33.5*	70.1 97.4*	No No
EX 2	4/3/10	39	80	No

*Results obtained with exercise

Narrative Medical Evidence

Claimant presented to Glen Baker, M.D., who is board-certified in internal medicine and the subspecialty of internal disease, on November 27, 2000. (DX 16). Dr. Baker completed a Department of Labor Medical History and Examination for Coal Workers' Pneumoconiosis form. He considered five years of coal mine employment at Bob & Tom Coal Company and a questionable amount with New Harlan Block, even though Claimant stated he has proof of twelve years of coal mine employment. He noted that Claimant had stopped smoking in 1995 after he smoked one-and-one-half packs of cigarettes per day since 1975. Claimant complained of dyspnea, a cough productive of sputum, and wheezing. Dr. Baker detected minimal coarse wheezing on auscultation of Claimant's lungs. He interpreted a chest x-ray as positive for pneumoconiosis. Dr. Baker found a pulmonary function test ("PFT") to show a mild obstructive defect. He found an arterial blood gas study ("ABG") to reveal mild resting arterial hypoxemia. An EKG showed normal sinus rhythm. Based upon his chest x-ray interpretation and Claimant's history of coal dust exposure, Dr. Baker diagnosed coal workers' pneumoconiosis ("CWP"). From the PFT he diagnosed chronic obstructive pulmonary disease ("COPD") with mild obstructive defect. He diagnosed hypoxemia based on the ABG. Lastly, based on Claimant's history of cough, sputum production, and wheezing, he diagnosed chronic bronchitis. Dr. Baker attributed Claimant's CWP solely to coal dust exposure and the other three diagnoses to a combination of coal dust exposure and cigarette smoking. He found that Claimant's pulmonary impairment was mild based on a decreased FEV1, bronchitis, decreased pO2, and CWP. Dr. Baker opined that Claimant's pulmonary impairment was caused by coal dust exposure and smoking. He found that Claimant retained the respiratory capacity to perform the work of a coal miner or comparable gainful work in a dust-free environment.

On December 5, 2000, J.D. Miller, M.D., who is board-certified in internal medicine, examined Claimant and completed a Kentucky Department of Workers' Compensation Programs Standard Form Medical Report for Occupational Disease. (DX 18). He considered that Claimant worked for twelve years in coal mining with a smoking history of about twenty years ending in 1995. Claimant complained of dyspnea on exertion, three pillow orthopnea, as well as frequent productive cough and wheezes. Dr. Miller noted that Claimant has had chronic hilar adenopathy since September of 1999. Clinical examination of Claimant's chest was clear to auscultation. He reviewed a chest x-ray performed by Dr. Tiu that showed a p/p, 2/1 profusion. Dr. Miller, in view of Claimant's history and physical taken together with his chest x-ray changes, years of working in the mines, and the results of his PFT, opined that Claimant suffers from a totally and permanently disabling lung condition which is primarily contributed to by his

having been exposed to coal dust while working in the mines. He noted that Claimant's FEV1 was below 55% of predicted. He stated that, when all of Claimant's history, physical, and x-ray findings are taken together with his PFT, he believes that the major contributing factor to Claimant's pulmonary dysfunction is from his exposure to coal dust while working in the mines. Dr. Miller noted that Claimant has an occupational disease caused by his coal mine employment based on an x-ray of 2/1 or higher. He stated that Claimant is totally and permanently disabled by a lung condition as evidenced by his PFT.

S.K. Paranthaman, M.D., who is board-certified in internal medicine and the subspecialty of pulmonary disease, examined Claimant on March 1, 2001 and issued a narrative report on March 19, 2001. (DX 41). He considered a coal mine employment history of twelve years (six underground and six around the tipple). Dr. Paranthaman noted that Claimant worked for F&D Coal Company from 1988 until 1994 when he quit due to shortness of breath. Claimant reported that his dyspnea is gradually increasing in intensity and gradual in onset over the past five years. He also complained of paroxysmal nocturnal dyspnea, the need for two pillows to sleep, and sputum that is occasionally blood streaked. Dr. Paranthaman noted Claimant's past diagnosis of asthma, as well as right shoulder pain from a rotator cuff tear that was surgically repaired in 1995. Dr. Paranthaman noted that Claimant smoked one-and-one-half packs per day for the last twenty-five years, ending in 1995. Claimant stated that he has not worked since 1994. Based on general appearance, Claimant was determined to be obese. Clinical examination of Claimant's chest detected normal percussion and a decrease in intensity of breath sounds bilaterally. No rales or wheezing was found. He reviewed a chest x-ray graded as a number 2 due to poor inspiratory effort, which he interpreted as p/p, 1/1, bilaterally. Dr. Paranthaman submitted Claimant to a PFT, but Claimant gave suboptimal effort and the tracings are not reproducible within 5% variance. The MVV values were quite low when compared to the FEV1 values. An ABG showed mild hypoxemia. An EKG showed non-specific changes. Dr. Paranthaman found that Claimant's twelve years of coal mine employment is sufficient to cause CWP in a susceptible individual. He opined that Claimant has simple CWP, noting that there has been consistent readings of simple pneumoconiosis in all but one examination (he referenced seven positive x-ray interpretations from 1995, 2000, and 2001). He found that Claimant's PFT was not valid, but noted that it did not show any change since 1995 (he referenced six PFTs from 1995, 2000, and 2001). Dr. Paranthaman found that Claimant's mild hypoxemia may be due to V/Q abnormalities secondary to obesity and consequent micro atelectasis in the lung bases, but noted that it may also be due to coal dust exposure. However, Dr. Paranthaman found that it is more likely due to V/Q abnormalities secondary to obesity rather than CWP because there was improvement in pO2 during previous exercise versions of an ABG. He assessed Claimant's level of overall impairment as mild, noting that he considers Claimant to have sufficient respiratory capacity to do the job of a coal miner. Dr. Paranthaman found that Claimant probably has asthma in addition to simple CWP, which might contribute to his shortness of breath significantly. Lastly, he noted that obesity can cause reduced FVC and reduced pO2 at rest, as well as producing a significant impairment to do heavy manual work.

Abdul Dahhan, M.D., who is board-certified in internal medicine and the subspecialty of pulmonary disease, issued a report on March 30, 2001. (DX 39). He considered a twelve year history of coal mine employment and a smoking history beginning at the age of eighteen in the

amount of one pack per day ending at the age of thirty-five. Claimant complains of a daily history of cough with sputum production, intermittent wheeze, and dyspnea on exertion. Dr. Dahhan documented a history of arthritis, surgery on his left knee, surgery on his right shoulder, and a hemorrhoidectomy. Clinical examination of Claimant's chest showed good air entry with no crepitations, rhonci, or wheeze. EKG was normal. An ABG showed minimum hypoxemia, with normal values at the end of exercise. Spirometry showed less than optimal effort, which was entirely invalid after bronchodilators and an invalid MVV on both occasions. A chest x-ray showed clear lungs. Dr. Dahhan also reviewed and summarized some of Claimant's medical records. He opined that there is insufficient objective data to justify a diagnosis of CWP based on normal spirometry (when studies were valid), adequate blood gas exchange, negative x-ray reading, and normal clinical examination of the chest. He determined that Claimant has a mild respiratory impairment due to his excessive obesity with no evidence of total or permanent pulmonary disability. Dr. Dahhan found no evidence of pulmonary disease or impairment caused by the inhalation of coal dust or CWP based on a normal clinical examination, adequate blood gases, and normal spirometry when the study is valid.

On April 23, 2001, Bruce Broudy, M.D., who is board-certified in internal medicine and the subspecialty of pulmonary disease, issued a consultative report after reviewing Claimant's medical records. (EX 3). He interpreted a chest x-ray from March 27, 2001 as negative. He reviewed Dr. Dahhan's report from March 27, 2001, which noted a coal mine employment history of twelve years and a smoking history of one pack per day from age eighteen to age thirty-five. He also reviewed Dr. Miller's report dated December 5, 2000 and a CT-scan report from October 31, 2000, in addition to several medical reports from 1995. Dr. Broudy found the evidence to show that Claimant was massively obese with a restrictive defect secondary to his obesity. He attributes the abnormalities on x-rays to underpenetration of the film with suboptimal inspiration. Dr. Broudy finds no evidence of radiographic progression, nor even definite evidence that Claimant has pneumoconiosis. He opined that Claimant is not totally disabled due to any cause. If Claimant does have an impairment, it is a mild restrictive defect due to obesity. Dr. Broudy found no evidence of a worsening of Claimant's lung function due to coal dust exposure or CWP. If Claimant did experience a worsening, it was due too cigarette smoking and obesity. Since Claimant provided varying effort on his PFTs, the most that can be said is that Claimant has a mild impairment.

N.K. Burki, M.D., who is board-certified in internal medicine and the subspecialty of pulmonary disease, examined Claimant on April 28, 2001 and completed a Kentucky Department of Workers' Compensation Disability Evaluation for Pneumoconiosis form. (EX 2). Claimant complained of an inability to breathe for the past six years and a difficulty walking up stairs. Dr. Burki considered a smoking history of one-and-one-half packs per day for twenty years, which ended in 1995. Upon physical examination, Dr. Burki found Claimant to be obese with no shortness of breath at rest and lungs clear to auscultation. He reviewed a chest x-ray dated April 3, 2001 which he noted revealed no pneumoconiosis and a PFT of the same date that he interpreted as showing a restrictive defect due to obesity. He opined that any pulmonary impairment is not caused by coal dust exposure. Dr. Burki stated that no restrictions should be placed on Claimant's exposure to coal dust. He found that Claimant retained the physical capacity to return to the type of work performed at the time of the injury.

Gregory Fino, M.D., who is board-certified in internal medicine and the subspecialty of pulmonary disease, issued a consultative report on May 11, 2001 after he reviewed and summarized Claimant's medical records. (DX 40). He commented that the PFT performed by Dr. Paranthaman does not represent Claimant's true lung function due to poor effort. Dr. Fino considered a coal mine employment history of twelve years, ending in 1994, and a smoking history of one to one-and-one-half packs per day for twenty-five years, ending in 1995. He interpreted a chest x-ray dated March 1, 2001 as positive for pneumoconiosis. Dr. Fino stated that he believes that CWP is present radiographically. He found absolutely no evidence of a respiratory impairment or a pulmonary disability since there is no objective evidence. According to the objective evidence he reviewed, there is no evidence that the inhalation of coal mine dust caused or contributed to any type of disability. In fact, irrespective of cause, Dr. Fino found no evidence at all of any pulmonary disability.

Moez Premji, M.D. answered questions posed by counsel for Claimant on December 17, 2002. (CX 3). Dr. Premji, who has treated Claimant for COPD and GERD since October of 1996, first diagnosed Claimant as suffering from CWP on September 1, 1999 after consulting a with Dr. Nelson Yu, a pulmonologist. Dr. Premji opined that Claimant's COPD is moderate. He prescribes Serevent and Proventil inhalers to treat Claimant's COPD. Dr. Premji answered "Yes" to the question of whether Claimant's COPD would prevent him from performing the normal manual labor of a coal miner. However, Dr. Premji could not answer the question of whether Claimant's history of 6-12 years of coal mine employment would be a significant contributing factor to Claimant's COPD and respiratory disabling condition.

Dr. Dahhan issued a supplemental consultative report on October 30, 2001. (DX 46). He reviewed and summarized some of Claimant's medical records, including chest x-rays and reports from Dr. Yu. Based on his prior review of medical records and the new records he reviewed, he found that Claimant had insufficient objective data to justify the diagnosis of CWP based on the clear lungs on clinical examination as noted by himself and Dr. Yu, negative x-ray readings for CWP, mild reduction in ventilatory capacity, and adequate blood gas exchange. He also found that Claimant had no evidence of total or permanent pulmonary disability based on the various clinical and physiological parameters of his respiratory system. Dr. Dahhan noted that Claimant's mild, intermittent asthma, as diagnosed by Dr. Yu, is a condition of the general public that is not affected by coal dust or CWP. Dr. Dahhan found no evidence of pulmonary impairment or disability caused by the inhalation of coal dust or CWP based on the entire medical record.

Dr. Dahhan issued another supplemental consultative report on June 30, 2002. (EX 4). He interpreted a chest x-ray dated March 27, 2001 as negative for pneumoconiosis. He also reviewed and summarized Claimant's medical records. Dr. Dahhan set forth the following conclusions, which were based on his prior examinations of Claimant and his review of Claimant's medical records. First, Dr. Dahhan found that there are insufficient objective findings to justify a diagnosis of CWP based on intermittent obstructive abnormalities on clinical examination of the chest, mild obstructive defect on spirometry, ad adequate blood gas exchange mechanisms at rest and after exercise. He noted that Claimant's physician was treating him for

intermittent asthma and abnormal chest x-ray with possible pneumoconiosis. From a respiratory standpoint, Dr. Dahhan found that Claimant has no evidence of total or permanent pulmonary disability based on the various psychological parameters of Claimant's respiratory system. Additionally, Dr. Dahhan noted that Claimant's carboxyhemoglobin level in March of 2001 was 7.5%, which is consistent with an individual smoking two packs per day. Dr. Dahhan found no evidence of pulmonary impairment or disability due to Claimant's coal dust exposure or CWP. Even if Claimant were found to have radiological evidence of CWP, Dr. Dahhan would still conclude that, from a functional standpoint, Claimant has no evidence of pulmonary disability. Dr. Dahhan would find that Claimant retains the respiratory capacity to continue his previous coal mine employment or a job of comparable physical demand.

Hospital & Treatment Records

Claimant first presented to the Ambulatory-Patient Clinic at the Daniel Boone Clinic in Harlan, Kentucky on December 15, 1998. (CX 1). He was evaluated by Dr. Premji. He was noted to have a history of COPD and reflux disease. Claimant complained of chest congestion, yellow sputum, and some chest pain. He was noted to be a non-smoker who quit four years ago. His chest was clear with left basil rhonchi. Dr. Premji's assessment was acute bronchitis. Claimant was provided with samples of Ceclor and Proventil.

On August 17, 1999, Claimant was examined by Dr. Premji, who noted that Claimant had a history of COPD. Claimant complained of shortness of breath, dry cough, and rattling in the chest. Claimant was noted as a non-smoker. Upon physical examination, Dr. Premji found Claimant's chest to be clear with some expiratory rhonchi and some right basilar crepitations. Dr. Premji's assessment was COPD with right basilar crepitations. Dr. Premji prescribed medication and a follow-up visit in two weeks with a chest x-ray. Dr. Premji examined Claimant two weeks later on August 31, 1999. Claimant again complained of shortness of breath and cough. Dr. Premji noted that an x-ray that had been ordered showed fine diffuse reticular nodular interstitial processes. He noted that Claimant reported that he had previously been diagnosed with stage 1 pneumoconiosis. Dr. Premji's assessment was pneumoconiosis. He referred Claimant for a PFT, a CT chest with contrast, and then a pulmonology review by Dr. Nelson Yu.

Upon Dr. Premji's request, Nelson Yu, M.D. performed a consultative examination of Claimant on September 1, 1999. Dr. Yu noted a past medical history of probable bronchial asthma, seasonal allergic rhinitis, a question of CWP, and esophageal reflux. Claimant reported episodic shortness of breath associated with rattling in his chest. He submitted Claimant to a PFT that showed normal FEV1/FEV ration with an FEV1 that was 83% of predicted. Lung volumes and diffusion capacity were within normal limits. He reviewed a chest x-ray dated August 17, 1999 that showed diffuse reticular nodular interstitial processes. Dr. Yu noted that Claimant quit smoking in 1997, and that he had smoked one-and-one-half packs per day from age sixteen to age thirty-nine. He also considered a coal mine employment history of six years. Dr. Yu's examination of Claimant's chest was clear to auscultation with no wheezing. His impression was mild intermittent asthma with worsening during fall and spring and improvement in summer and winter. His other impression was a differential diagnosis of CWP versus

sarcoidosis. Dr. Yu's plan was to provide a Pulmicort Turbuhaler, a Proventil inhaler, instructed Claimant on a peak flow meter. Claimant was to return in two weeks for a CT scan. He noted that a combination of hilar lymph nodes and interstitial infiltrates could point to sarcoidosis. Claimant presented to the emergency room at the Daniel Boone Clinic for symptoms of the flu on September 9, 1999. He was sent home, after being examined, with medication.

Dr. Premji examined Claimant again on February 21, 2000. He noted that the possibility of sarcoid needs to be entertained. Claimant did not keep his follow-up appointment with Dr. Yu. Dr. Premji detected slight expiratory rhonchi. His assessment was bronchitis. Dr. Premji prescribed Prednisone and Doxycycline, and advised Claimant to keep his appointments with Dr. Yu.

On February 28, 2000, Claimant returned to Dr. Yu, who recorded a history of mild intermittent asthma, seasonal allergic rhinitis, CWP, probable sarcoidosis, and esophageal reflux. Dr. Yu noted that Claimant's breathing has improved now that he does not do a lot of carpentry because he is working as a school bus driver. Dr. Yu referenced a CT scan from September 7, 1999. On auscultation, Claimant's chest was clear with wheezing only on forceful expiration. Dr. Yu's impression was probable sarcoidosis, CWP, and mild intermittent asthma. Dr. Yu provided Claimant with more inhalers and requested a follow-up visit.

Claimant returned to Dr. Yu on March 31, 2000 complaining of a rash. Upon clinical examination, Claimant's chest was clear to auscultation with no wheezing on forceful expiration. Dr. Yu's impression wax mild, intermittent asthma, seasonal allergic rhinitis, pruritus secondary to xerosis versus contact dermatitis, and mild hypertension. CWP was again noted under history.

On June 15, 2000, Claimant returned to Dr. Yu. Dr. Yu noted a past medical history of mild intermittent asthma, seasonal allergic rhinitis, CWP, and esophageal reflux. Claimant's chest was clear to auscultation with occasional wheezing on forceful expiration. Dr. Yu's impression was seasonal allergic rhinitis and nasopharyngitis with postnasal drip. Dr. Yu provided Claimant with samples of medication. Claimant returned to Dr. Yu on July 13, 2000, complaining that his left lung occasionally does not expand as well as the right lung when he takes a deep breath. He carried forward his notations of Claimant's medical history. Claimant's chest was clear to auscultation with no wheezing on forceful expiration. Dr. Yu's impression was seasonal allergic rhinitis, controlled, mild intermittent asthma, controlled, and CWP. Dr. Yu requested that Claimant return in three months for a chest x-ray to stage his CWP and to follow on the lymphadenopathy.

Claimant submitted to a chest x-ray as requested by Dr. Premji. Dr. Tiu, a radiologist, a found fine diffuse reticulonodular interstitial process in both lung fields that may represent underlying occupational pneumoconiosis. He also noted that persistent soft tissue fullness of both pulmonary hilum has not changed since 1996. Dr. Tiu recommended a CT scan of Claimants' chest. Claimant underwent a CT scan with IV contrast on September 7, 1999 as performed by Dr. Tiu. Dr. Tiu's impression was increased number of small nodes in both hilar regions, subcarinal regions, and anterior mediastinum were identified and represent a non-specific finding. Differential diagnosis will have to include hyperplastic lymphadenopathy

versus lymphoma versus sarcoidosis among other possibilities. Dr. Tiu also noted fine reticular nodular interstitial processes in both lung fields. He stated this finding suggests an underlying chronic interstitial pulmonary process which includes occupational pneumoconiosis. He also made an incidental finding of fat infiltration in the liver.

Dr. Tiu interpreted a chest x-ray dated October 2, 2000 on October 3, 2000. His findings were compatible with a diagnosis of simple pneumoconiosis. He noted soft tissue fullness in both pulmonary hilum and raised the possibility of bilateral hilar adenopathy. He recommended another CT scan.

On October 16, 2000, Claimant returned to Dr. Yu, who carried forward his prior notations regarding Claimant's medical history. He noted the results of a chest x-ray from October 2 that showed diffuse reticular interstitial changes in both lung fields and soft tissue fullness in both pulmonary hilum, which reveals the possibility of bilateral hilar adenopathy. Claimant's chest was clear to auscultation with no wheezing on forceful expiration. Dr. Yu's impression was persistent hilar adenopathy and reticular interstitial infiltrates. He stated though the infiltrates could represent CWP, the combination of the whole picture could still be consistent with sarcoidosis. He scheduled another CT scan, an angiotensin converting enzyme test for his asthma, and a follow-up in one month. He also called Dr. Tiu to stage the chest x-ray from October 2, 2000 for CWP.

Dr. Tiu performed another CT scan of Claimant's chest with IV contrast on October 31, 2000. He found an increased number of small lymph nodes in both hilar, subcarinal and anterior mediastinum since September of 1999. He found the presence of diffuse fine reticular nodular interstitial process again in both lung fields, which is compatible with occupational pneumoconiosis. Again, Dr. Tiu noted fatty infiltration of the liver.

Dr. Yu examined Claimant on November 20, 2000 and carried forward his previous notations of Claimant's medical history. However, this time he noted that Claimant's CWP was stage P/Q 2/1 and he added fatty infiltration of the liver. Claimant had no specific complaints and felt that his lungs are really in good condition for the fall. Dr. Yu noted that Claimant was still a school bus driver. He referenced the findings from the CT scan that was performed on October 31, 2000. Claimant's chest was clear to auscultation with no wheezes on forceful expiration. Dr. Yu's impression was CWP and mild intermittent asthma, quiescent. Dr. Yu encouraged Claimant to be hydrated and requested a follow-up visit in three months.

Claimant returned to Dr. Yu on January 18, 2001. Claimant presented to Dr. Yu because the Department of Labor, Office of Workers' Compensation Programs thought that his chest x-ray is abnormal and shows some hilar fullness. He continued to note a history of CWP stage P/Q 2/1, and he added obesity to the history list. Claimant's occupational history still reflects work as an underground miner for six years, but now included an additional six years around the coal tipple. Moreover, Dr. Yu noted that Clamant has been around the mines since he was six years old. Claimant was noted as presently working as a truck driver. Claimant's chest was clear to auscultation with no rales or wheezes. Dr. Yu's impression was CWP and allergic rhinitis. His plan was reassurance that hilar fullness that was found on the chest x-ray correlated with the hilar

lymph nodes that have been stable since September of 1999. He provided Claimant with medication and requested a follow-up in three months.

Claimant returned three months later on April 9, 2001. Dr. Yu's history of Claimant's medical conditions remained the same. Claimant has been doing fair since his last visit, but he still has shortness of breath because he only used his medication sparingly knowing that he cannot refill his prescription due to financial constraint. Claimant's chest was clear to auscultation with no rales or wheezes. Dr. Yu's impression was uncontrolled asthma and seasonal allergic rhinitis. He provided Claimant with medication and recommended a follow-up in six months for a PFT.

Smoking History

Claimant testified that he began smoking around the ages of fifteen or sixteen (1973 or 1974), quitting somewhere around 1995. (Tr. 39). At most, he smoked a pack per day, but he was not smoking a pack per day initially. (Tr. 46). The medical histories recorded by examining physicians consistently document a smoking history beginning between ages sixteen to eighteen and ending in 1995. The medical histories regularly note that Claimant smoked one pack to one-and-one-half packs per day. Therefore, I find that Claimant smoked one pack of cigarettes per day for twenty years.

DISCUSSION AND APPLICABLE LAW

Mr. Farmer's claim was made after March 31, 1980, the effective date of Part 718, and must therefore be adjudicated under those regulations. To establish entitlement to benefits under Part 718, Claimant must establish, by a preponderance of the evidence, the following elements:

1. That he suffers from pneumoconiosis;

2. That the pneumoconiosis arose, at least in part, out of coal mine employment;

3. That the claimant is totally disabled; and

4. That the total disability is caused by pneumoconiosis.

See §§ 719.3, 718.202, 718.203, 718.204; *Gee v. W.G. Moore*, 9 B.L.R. 1-4, 1-5 (1986); *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-212 (1985). Failure to establish any of these elements precludes entitlement. *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26, 1-27 (1987).

Duplicate Claim

Claimant's initial application for benefits was denied in 1996. He filed a second claim in November of 2000. The provisions of § 725.309 apply to new claims that are filed more than one year after a prior denial. Section 725.309 is intended to provide claimants relief from the

ordinary principles of *res judicata*, based on the premise that pneumoconiosis is a progressive and irreversible disease. *See Lukman v. Director, OWCP*, 896 F.2d 1248 (10th Cir. 1990); *Orange v. Island Creek Coal Company*, 786 F.2d 724, 727 (6th Cir. 1986); § 718.201(c) (Dec. 20, 2000). Section 725.309(d) provides that:

> If the earlier miner's claim has been finally denied, the later claim shall also be denied, on the grounds of the prior denial, unless the deputy commissioner determines that there has been a material change in conditions or the later claim is a request for modification and the requirements of § 725.310 are met.

The Benefits Review Board defined "material change in conditions" under § 725.309(d) as occurring when a claimant establishes, by a preponderance of the evidence developed subsequent to the prior denial, at least one of the elements of entitlement previously adjudicated against the claimant. *See Allen v. Mead Corp.*, 22 B.L.R. 1-61 (2000). The Board has also held that a material change in conditions may only be based upon an element which was previously denied. *Caudill v. Arch of Kentucky, Inc.*, 22 B.L.R. 1-97 (2000) (en banc on recon.) (where Administrative Law Judge found that claimant did not establish pneumoconiosis and did not specifically address total disability, the issue of total disability may not be considered in determining whether the newly submitted evidence is sufficient to establish a material change in conditions). Lay testimony alone is insufficient to establish a material change in conditions. *Madden v. Gopher Mining Co.*, 21 B.L.R. 1-122 (1999).

This matter arises under the jurisdiction of the Sixth Circuit Court of Appeals.[5] In *Tennessee Consolidated Coal Co. v. Director, OWCP [Kirk]*, 264 F.3d 602 (6th Cir. 2001), the Sixth Circuit held that, under *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994), it is insufficient for the ALJ to merely analyze the newly submitted evidence to determine whether an element previously adjudicated against the claimant has been established. An administrative law judge must also compare the sum of the newly submitted evidence against the sum of the previously submitted evidence to determine whether the new evidence is substantially more supportive of claimant. *Kirk*, 264 F.3d at 609. However, when comparing the newly submitted evidence against the previously submitted evidence, only a substantial difference in the bodies of evidence is required, not a complete absence of evidence at the earlier time. *Id.* at 610 It is legal error for an administrative law judge not to show that there was a worsening of Claimant's condition on the element selected to show a material change. *Id.* at 609.

Claimant's initial claim was denied because he failed to establish that his pneumoconiosis arose out of coal mine employment and because he failed to establish that he was totally disabled due to pneumoconiosis. The claims examiner from the OWCP found that the evidence established the existence of pneumoconiosis. Claimant's duplicate claim must be denied on the basis of the prior denial, unless he establishes that his pneumoconiosis arose out of coal mine employment or that he is totally disabled due to pneumoconiosis. For purposes of duplicate

[5] Appellate jurisdiction with a federal circuit court of appeals lies in the circuit where the miner last engaged in coal mine employment, regardless of the location of the responsible operator. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200 (1989)(en banc). Miner last engaged in coal mine employment in Kentucky.

claim analysis only, it must be assumed that Claimant has established the existence of pneumoconiosis. If Claimant establishes a material change in conditions, which obligates the undersigned to conduct a *de novo* review of all of the evidence of record, then Claimant must establish by a preponderance of the evidence that he suffers from pneumoconiosis.

Arising out of Coal Mine Employment

To establish a material change in conditions, Claimant must prove that his pneumoconiosis arose, at least in part, out of his coal mine employment. § 718.203(a). For a miner who suffers from pneumoconiosis and was employed for ten or more years in one or more coal mines, it is presumed that his pneumoconiosis arose out of his coal mine employment. *Id.* I determined that Claimant has established six years of coal mine employment. Thus, Claimant is not entitled to rely upon the rebuttable presumption set forth in § 718.203(b). If a miner who is suffering from pneumoconiosis was employed less than ten years in the nation's coal mines, it shall be determined that such pneumoconiosis arose out of that employment only if competent evidence establishes such a relationship. § 718.203(c). The Benefits Review Board has determined that "competent evidence" establishes the relationship between pneumoconiosis and coal mine employment when pneumoconiosis is significantly related to or substantially aggravated by the dust exposure of coal mine employment. *Shoup v. Director, OWCP*, 11 B.L.R. 1-110, 1-112 (1987). However, the Sixth Circuit only requires that a miner's pneumoconiosis arise "in part" from his coal mine employment. *Southard v. Director, OWCP*, 732 F.2d 66, 6 B.L.R. 2-26 (6th Cir. 1984). The relationship between pneumoconiosis and coal mine employment must be established by reliable medical evidence; lay testimony and medical opinions predicated on erroneous coal mine employment histories are insufficient. *See Baumgartner v. Director, OWCP*, 9 B.L.R. 1-65, 1-66 (1987); *Barnes v. Director, OWCP*, 19 B.L.R. 1-71 (1995) (en banc on reconsideration); *Tucker v. Director, OWCP*, 10 B.L.R. 1-35, 1-39 (1987).

Dr. Baker opined that Claimant's pneumoconiosis was due to coal dust exposure based on his chest x-ray interpretation and Claimant's history of coal mine employment of six to twelve years. He also attributes Claimant's COPD, mild hypoxemia, and chronic bronchitis to a combination of coal mining and smoking. Dr. Miller, who considered a twelve year history of coal dust exposure, found that Claimant suffered from a pulmonary impairment primarily contributed to by his having been exposed to coal dust while working in the mines. Dr. Miller based his opinion on a chest x-ray interpretation, Claimant's history and physical examination, and the results of the PFT he performed. Dr. Miller also considered an accurate account of Claimant's smoking history. Dr. Paranthaman found that Claimant had simple CWP based on his review of seven positive chest x-rays. Dr. Premji also found that Claimant suffered from CWP based on his consultation with Dr. Yu.

Dr. Dahhan on three occasions, after examining Claimant and reviewing medical records, found that there is insufficient evidence to justify a diagnosis of pneumoconiosis. He also found that there was no evidence of pulmonary disease or impairment caused by the inhalation of coal dust or CWP itself based on normal clinical examinations, adequate blood gases, and normal spirometry when the test is valid. I accord less weight to Dr. Dahhan's opinions since he did not

diagnose the existence of pneumoconiosis. He did offer an opinion, assuming a finding of pneumoconiosis, that Claimant was not functionally impaired by CWP. However, since he didn't find the existence of pneumoconiosis, he did not offer an opinion as to whether the pneumoconiosis arose out of coal mine employment. Dr. Dahhan's opinions are reasoned and documented, but he only relies upon the evidence that supports his opinion. He ignores the contradictory evidence and does not offer any rationale to distinguish his opinion.

Dr. Broudy reviewed Claimant's medical records and reaches a consensus from the histories provided that Claimant engaged in twelve years of coal mine employment. He also considered an accurate smoking history. Dr. Broudy found no evidence of radiographic progression of pneumoconiosis, in fact, he did not even find definite evidence that Claimant even suffered from pneumoconiosis. He determined that Claimant was massively obese, and that Claimant's obesity caused a restrictive lung defect. Dr. Broudy attributed the abnormalities seen on the chest x-rays to underpenetration of the film with suboptimal inspiration.

Dr. Burki found that Claimant was obese, and that his obesity caused a restrictive defect. He found no evidence of CWP. Since he did not diagnose the existence of pneumoconiosis, he did not offer an opinion as to whether the pneumoconiosis arose out of coal mine employment.

Dr. Fino found that Claimant suffered from coal workers' pneumoconiosis based on his x-ray interpretation. He considered a coal mine employment history of twelve years and an accurate smoking history.

Claimant presented to Dr. Yu on at least eight occasions. Dr. Yu reviewed several PFTs, chest x-rays, and CT scans of Claimant's chest that were obtained and interpreted by Dr. Tiu. Dr. Yu noted Dr. Tiu's x-ray and CT scan findings of fine reticular nodular interstitial process in both lung fields. Dr. Yu considered differential diagnoses of sarcoidosis or occupational pneumoconiosis. Eventually, Dr. Yu definitively diagnosed CWP. I infer that Dr. Yu ruled out sarcoidosis as a potential diagnosis because his records do not refer to the possibility of sarcoidosis by November of 2000. For most of his treatment relationship, and at the time Dr. Yu first diagnosed Claimant as suffering from CWP, he considered a coal mine employment history of six years in addition to an accurate smoking history. Dr. Yu noted that Claimant was obese. Dr. Yu's opinion is reasoned and documented. His opinion is founded on clinical findings and observations. His reasoning is more than adequately supported by the objective data he reviewed. He considered all potential causes of Claimant's radiographic abnormalities, and still diagnosed CWP. I accord greater probative weight to the opinion of Dr. Yu based on the quality of his reasoning, which was aided by numerous physical examinations of Claimant.

Dr. Yu's opinion is supported by the CT scans obtained and interpreted by Dr. Tiu. Dr. Tiu, through chest x-ray interpretations and CT scans, found the presence of a fine reticular nodular interstitial process in both lung fields that was compatible with occupational pneumoconiosis.

Claimant was only able to establish six years of coal mine employment. His first five years of coal mining were spent at the face of a coal mine. His sixth year was spent operating a

tipple. Claimant lived one-hundred to two-hundred feet away from the coal tipple for at least one-and-one-half years, and possibly for at least four more years. Dr. Yu determined that Claimant's interstitial lung process was caused by Claimant's exposure to coal dust. He considered an accurate account of Claimant's smoking history and coal mine employment history, and he noted that Claimant was obese. Drs. Miller, Premji, Fino, and Paranthaman found that Claimant was suffering from coal workers' pneumoconiosis. Dr. Tiu, following several chest x-rays and CT scans, found Claimant's interstitial lung process to be compatible with occupational pneumoconiosis. Drs. Broudy, Burki, and Dahhan found that Claimant did not suffer from pneumoconiosis. I find the opinions of Drs. Yu, Miller, Premji, Fino, and Paranthaman that Claimant suffered from coal workers' pneumoconiosis are controlling. Their opinions are supported by the CT scan interpretations of Dr. Tiu. The preponderance of the medical evidence establishes that Claimant's pneumoconiosis arises, at least in part, out of his coal dust exposure.

The sum of the newly submitted evidence must now be compared against the sum of the previously submitted evidence to determine if the evidence differs qualitatively. The prior denial of benefits, issued by an OWCP claims examiner on August 1, 1996, does not specifically identify the evidence that was considered. Therefore, I will compare all evidence dated before August 1, 1996 that was submitted to the OWCP while Claimant's initial claim was pending.

Dr. Baker conducted a PFT on February 28, 1995 that did not produce values that would qualify for total disability. Similarly, a June 9, 1995 PFT did not produce values that would qualify for total disability.

Dr. Dahhan examined Claimant on July 26, 1995. Dr. Dahhan considered a 12 year history of coal mine employment and a smoking history of one-and-one-half packs of cigarettes per day for twenty years. Claimant complained of daily cough, frequent wheeze, and dyspnea on exertion. Examination of Claimant's chest was clear with good air entry. An EKG was normal. An ABG showed minimal resting hypoxemia, and two attempts at spirometry were considered invalid due to more than 5% variation in the curves, excessive hesitation, and lack of plateau formation. Dr. Dahhan interpreted a chest x-ray as negative. Dr. Dahhan concluded that there was insufficient evidence to justify a diagnosis of CWP based on a normal clinical examination of Claimant's chest, negative x-ray, and adequate blood gas exchange. He could not assess Claimant's pulmonary capacity due to invalid effort on spirometry, but he noted that all parameters of his respiratory system show no significant impairment or disability. He attributed the cause of Claimant's chronic bronchitis to his twenty pack years of cigarette smoking. Dr. Dahhan found that Claimant continued to smoke.

On March 19, 1996, Dr. Baker conducted a physical examination of Claimant and completed a Department of Labor Medical History and Examination for Coal Workers' Pneumoconiosis form. He considered a twelve year history of coal mining. He noted that Claimant was currently smoking and that he had been smoking one-and-one-half packs per day since 1975. Dr. Baker detected decreased breath sounds and scattered wheezing. He diagnosed CWP based on a positive chest x-ray interpretation and significant history of coal dust exposure. Dr. Baker also diagnosed COPD from the PFT, hypoxemia from the ABG, and chronic

bronchitis based on Claimant's history of cough, sputum production, and wheezing. Dr. Baker attributed his diagnosis of CWP to coal dust exposure, and the remaining three diagnoses to coal dust exposure and cigarette smoking. He found that Claimant had a moderate impairment.

Dr. Sargent, who is dually-certified as a board-certified radiologist and B-reader, reread Dr. Baker's positive x-ray interpretation from March 19, 1996 as negative, while Dr. Barrett, also a dually-certified physician reread the same x-ray as positive. Dr. Powell, a B-reader, and Drs. Wiot and Spitz, who are both dually-certified physicians, all reread Dr. Dahhan's June 26, 1995 x-ray as negative.

The sum of the evidence available to the OWCP claims examiner showed that Claimant's chest x-ray was negative for pneumoconiosis in June of 1995, and positive for pneumoconiosis by March of 1996 (based on a positive reading from a dually-certified physician and a B-reader that outweigh one negative interpretation from a dually-certified physician). Dr. Dahhan found no evidence of clinical or legal pneumoconiosis in June of 1995. Less than one year later, Dr. Baker diagnosed clinical and legal pneumoconiosis.

In comparison to one negative x-ray and one negative narrative opinion followed by a positive x-ray and narrative opinion for the existence of coal workers' pneumoconiosis eleven months later, the newly submitted evidence strongly established a causal relationship between Claimant's occupational exposure to coal dust and his pneumoconiosis. The newly submitted CT scan and chest x-ray evidence, along with the narrative opinion evidence of Dr. Yu identifies a causal relationship between Claimant's occupational exposure to coal dust and his pneumoconiosis in a manner that is qualitatively different than one positive chest x-ray and one narrative opinion finding CWP on a Department of Labor form. Claimant has established an element of entitlement previously adjudicated against him through newly submitted evidence that is qualitatively different than the prior evidence. Therefore, I find that the evidence establishes a material change in conditions. The entire record must now be reviewed *de novo* to determine whether the preponderance of the evidence establishes that Claimant is totally disabled due to pneumoconiosis arising out of his coal mine employment.

Pneumoconiosis

In establishing entitlement to benefits, Claimant must initially prove the existence of pneumoconiosis under § 718.202. Claimant has the burden of proving the existence of pneumoconiosis, as well as every element of entitlement, by a preponderance of the evidence. *See Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994). Pneumoconiosis is defined by the regulations:

For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical" pneumoconiosis and statutory, or "legal" pneumoconiosis.

(1) *Clinical Pneumoconiosis*. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis,anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) *Legal Pneumoconiosis*. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
Section 718.201(a).

Section 718.202(a) sets forth four methods for determining the existence of pneumoconiosis.

(1) Under § 718.202(a)(1), a finding that pneumoconiosis exists may be based upon x-ray evidence. The record consists of twenty-six interpretations of eight x-rays. The first x-ray was taken on July 26, 1995. All four interpretations were negative. Thus, I find that the x-ray dated July 26, 1995 is negative. The next x-ray was taken on March 19, 1996. Dr. Baker, a B-reader, found the film to be positive for pneumoconiosis, as did Dr. Barrett, who is dually certified as a B-reader and board-certified radiologist. Dr. Sargent, who is also dually-certified, interpreted the film as negative. Drs. Sargent and Barrett are equally qualified, but when combined weight of Dr. Baker's interpretation, a preponderance of the evidence establishes that the March 19, 1996 x-ray is positive.

The next x-ray for consideration was taken more than four years later on October 2, 2000. Dr. Tiu found it to be positive. There were no contradictory opinions. Thus, I find that the October 2, 2000 x-ray is positive. Dr. November 27, 2000. Drs. Baker and Barrett again issued a positive interpretations. Two dually-certified physicians, Drs. Sargent and Spitz, as well as a B-reader, Dr. Lockey, found the x-ray to be negative. The three negative interpretations, in light of the rendering physicians' credentials, establish that the film is negative. Another x-ray was obtained on March 1, 2001. All three interpretations of the x-ray are positive; two positive interpretations from B-readers and one positive interpretation from a dually-certified physician. Since all interpretations are positive, I find that the March 1, 2001 x-ray is positive for the existence of pneumoconiosis.

All six of the interpretations rendered from a film dated March 27, 2001 were negative. Five of the seven negative interpretations were issued by dually-certified physicians, while the remaining two negative interpretations were issued by B-readers. Since all interpretations were negative, I find that the March 27, 2001 x-ray is negative for the existence of pneumoconiosis. Dr. Lieber, a dually-certified physician issued the only interpretation of a film dated April 3, 2001. He found the film to be negative. Thus, I find that the April 3, 2001 x-ray is negative. Drs. Powell and Dahhan, both B-readers, issued negative interpretations of an x-ray obtained on April 27, 2001. There were no other interpretations. Accordingly, I find that the April 27, 2001 x-ray is negative.

In sum, eight of the twenty-six interpretations were positive compared with eighteen negative interpretations. Of the eight x-rays, I determined that three were positive and five were negative. Of the more recent x-rays, which were taken between October 2000 and April 2001, two were positive and four were negative. The preponderance of the x-ray evidence is negative. Therefore, I find that Claimant has not established the existence of pneumoconiosis by chest x-ray evidence under subsection (a)(1).

(2) Under § 718.202(a)(2), a determination that pneumoconiosis is present may be based, in the case of a living miner, upon biopsy evidence. Claimant submitted a pathology report prepared by Syed Ally, M.D., a pathologist, from a sputum and cell block sample obtained from Claimant. Dr. Ally performed a gross and microscopic examination. Dr. Ally found that the sample was negative for atypia or malignancy. There was no diagnosis compatible with legal or clinical pneumoconiosis. Therefore, I find that the Claimant has failed to establish the existence of pneumoconiosis through biopsy evidence under subsection (a)(2).

(3) Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found to be applicable. In this case, the presumption of § 718.304 does not apply because there is no evidence in the record of complicated pneumoconiosis. Section 718.305 is not applicable to claims filed after January 1, 1982. Finally, the presumption of § 718.306 is applicable only in a survivor's claim filed prior to June 30, 1982. Therefore, Claimant cannot establish pneumoconiosis under subsection (a)(3).

(4) The fourth and final way in which it is possible to establish the existence of pneumoconiosis under § 718.202 is set forth in subsection (a)(4) which provides in pertinent part:

> A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

§ 718.202(a)(4).

This section requires a weighing of all relevant medical evidence to ascertain whether or not the claimant has established the presence of pneumoconiosis by a preponderance of the evidence. Any finding of pneumoconiosis under § 718.202(a)(4) must be based upon objective medical evidence and also be supported by a reasoned medical opinion. A reasoned opinion is one which contains underlying documentation adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which he bases his diagnosis. *Oggero v. Director, OWCP*, 7 B.L.R. 1-860 (1985).

Dr. Dahhan examined Claimant on July 26, 1995. He opined that Claimant did not suffer from pneumoconiosis.

On March 19, 1996, Dr. Baker examined Miner and opined that Claimant suffered from pneumoconiosis based on his positive chest x-ray reading and Claimant's history of coal dust exposure. He also found that Claimant suffered from COPD, hypoxemia, and chronic bronchitis arising out of coal dust exposure and smoking based on Claimant's PFT, ABG, and history of chronic bronchitis. The Sixth Circuit Court of Appeals has held that merely restating an x-ray is not a reasoned medical judgment under § 718.202(a)(4). *Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6th Cir. 2000). The Board has also explained that, when a doctor relies solely on a chest x-ray and coal dust exposure history, a doctor's failure to explain how the duration of a miner's coal mine employment supports his diagnosis of the presence or absence of pneumoconiosis renders his opinion "merely a reading of an x-ray . . . and not a reasoned medical opinion." *Taylor v. Brown Bodgett, Inc.*, 8 B.L.R. 1-405 (1985). *See also Worhach v. Director, OWCP*, 17 B.L.R. 1-105, 1-110 (1993) (citing *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-113 (1989)(it is permissible to discredit the opinion of a physician which amounts to no more than a restatement of the x-ray reading). Dr. Baker's diagnosis of pneumoconiosis does not constitute a reasoned medical judgment. However, Dr. Baker's diagnosis of COPD, hypoxemia, and chronic bronchitis arising out of coal dust exposure and smoking is a diagnosis of legal pneumoconiosis. Dr. Baker set forth clinical observations and findings, and his reasoning is supported by adequate data. His opinion is reasoned and documented. I find that Dr. Baker's diagnosis of legal pneumoconiosis is entitled to probative weight.

Dr. Premji examined Claimant in December of 1998 and assessed Claimant as suffering from chronic bronchitis. He did not provide an opinion as to the etiology of the chronic bronchitis. In August of 1999, Claimant returned to Dr. Premji. This time, after reviewing a chest x-ray interpretation that revealed the presence of fine diffuse reticular nodular interstitial processes, Dr. Premji diagnosed pneumoconiosis. Despite performing a physical examination that detected rhonchi and basilar crepitations, Dr. Premji did not identify any other factor besides the chest x-ray when diagnosis pneumoconiosis. Thus, I find that Dr. Premji's diagnosis does not constitute a reasoned medical judgment. Dr.

Premji referred Claimant to Dr. Yu for a pulmonology consult, so that Claimant could undergo a PFT and a CT scan.

Dr. Yu performed a complete pulmonary examination on Claimant in September of 1999. He noted Claimant's medical history and subjective complaints. He performed a PFT and reviewed a chest x-ray. His impression was mild asthma and a differential diagnosis of CWP versus sarcoidosis. After Claimant underwent a CT scan, he returned to Dr. Yu. After examining Claimant, Dr. Yu diagnosed probable sarcoidosis, CWP, and mild intermittent asthma. Claimant presented to Dr. Yu several times during 2000, and each time Dr. Yu noted CWP as a diagnosis under Claimant's medical history. In October of 2000, Dr. Yu reviewed another chest x-ray. He opined that the infiltrates evident in the x-ray could be CWP, or the whole picture of Claimant's medical symptoms could show sarcoidosis. In November of 2000, Dr. Yu reviewed a CT scan, and offered his impression that Claimant suffered from CWP and mild intermittent asthma. He did not mention sarcoidosis. After examining Claimant in 2001, Dr. Yu continued to diagnose CWP. Dr. Yu examined Claimant on at least eight occasions from September of 1999 through April of 2001. He submitted Claimant to objective testing, reviewed chest x-rays and CT scans, and considered an accurate account of Claimant's smoking and coal mine employment histories. His initial diagnosis of CWP was a differential diagnosis, but he eventually ruled out sarcoidosis and thereafter stated his impression was CWP. Dr. Yu set forth clinical observations and findings and his reasoning is supported by adequate data. His opinion is reasoned and documented; it was not merely based on his chest x-ray interpretations. I find that Dr. Yu's opinion is entitled to probative weight.

Dr. Tiu conducted his first CT scan of Claimant in September of 1999, upon Dr. Yu's request. Dr. Tiu suggested that the presence of fine reticular nodular interstitial processes in Claimant's lungs could be an occupational pneumoconiosis. He also issued a differential diagnoses of lymphadenopathy versus lymphoma versus sarcoidosis versus other possibilities. Dr. Tiu performed a second CT scan in October of 2000, after identifying chest x-ray findings compatible with a diagnosis of simple pneumoconiosis. He again identified the presence of diffuse fine reticular nodular interstitial processes which is compatible with occupational pneumoconiosis. Dr. Tiu's CT scan interpretations identify the presence of an occupational pneumoconiosis. While Dr. Tiu did not specifically diagnose clinical pneumoconiosis, because he did not opine that it arose out of coal mine employment, I find his opinion to be probative. His opinion supports a finding of pneumoconiosis.

Claimant returned to Dr. Baker in 2000. Dr. Baker considered an accurate account of Claimant's smoking and coal mine employment histories. Again, Dr. Baker diagnosed pneumoconiosis based on his chest x-ray interpretation and Claimant's history of coal dust exposure. As he did in 1996, he also diagnosed COPD, hypoxemia, and chronic bronchitis arising out of Claimant's history of coal dust exposure and smoking. Dr. Baker's diagnosis of clinical pneumoconiosis is not a reasoned medical opinion, however, he also diagnosed legal pneumoconiosis. Dr. Baker submitted Claimant to objective testing and considered his subjective complaints. He set forth clinical

observations and findings, and his reasoning is supported by adequate data. His opinion is reasoned and documented. I find that Dr. Baker's diagnosis of legal pneumoconiosis is entitled to probative weight.

Dr. Miller also examined Claimant in 2000. He opined that Claimant suffers from a totally and permanently disabling lung condition that was primarily contributed to by exposure to coal dust. Dr. Miller's opinion was based on Claimant's history and physical examination, together with Claimant's chest x-ray changes, history of coal mine work, and the results of Claimant's PFT. Dr. Miller set forth clinical observations and findings, and his reasoning is supported by adequate data. He considered a sufficiently accurate account of Claimant's coal mine employment and smoking histories. His opinion is reasoned and documented. I find that Dr. Miller's opinion is entitled to probative weight enhanced by his board-certification in internal medicine.

Dr. Paranthaman examined Claimant several months later in 2001. He opined that Claimant had simple CWP, noting that there had been consistent x-ray interpretations finding the presence of simple CWP. He asserted that Claimant's mild hypoxemia may be due to heart abnormalities secondary to obesity. He allowed that it might also be due to coal dust exposure, but found it more likely due to obesity because Claimant's pO2 values showed improvement after exercise. Dr. Paranthaman also opined that Claimant may have asthma, which might contribute to his shortness of breath. He commented that obesity can lead to reduced FVC values and reduced pO2 values at rest, in addition to producing a significant impairment to do heavy work. Dr. Paranthaman's diagnosis of simple clinical pneumoconiosis does not constitute a reasoned medical opinion, as it is only based on chest x-ray interpretations. Even though he allows for the possibility that Claimant's hypoxemia may be caused by coal dust exposure, Dr. Paranthaman finds it to more likely have been caused by Claimant's obesity. I do not consider his opinion to be ambiguous. He identified a possibility of legal pneumoconiosis, but provided adequately supported rationale to attribute Claimant's hypoxemia to obesity. Dr. Paranthaman submitted Claimant to objective testing, reviewed some of Claimant's medical records, and considered a sufficiently accurate of Claimant's smoking and coal mine employment histories. He set forth clinical observations and findings, and his reasoning is supported by adequate data. His opinion is reasoned and documented. I find that Dr. Paranthaman's opinion is entitled to probative weight enhanced by his credentials as a board-certified pulmonologist.

Dr. Dahhan examined Claimant again in March of 2001. He found that there is insufficient evidence to diagnose CWP based on normal valid spirometry, adequate blood gas exchange, a negative x-ray reading, and a normal clinical examination of Claimant's chest. He also found no evidence of any pulmonary disease or impairment caused by the inhalation of coal dust. He attributed Claimant's pulmonary impairment to obesity. Dr. Dahhan submitted Claimant to objective testing and considered a sufficiently accurate account of Claimant's smoking and coal mine employment histories. He set forth clinical observations and findings, and his reasoning is supported by adequate data. His opinion is reasoned and documented. I find that Dr. Dahhan's opinion that Claimant does not

suffer from clinical or legal pneumoconiosis is entitled to probative weight enhanced by his credentials as a board-certified pulmonologist.

Dr. Broudy examined Claimant one month after Dr. Dahhan. He reviewed Claimant's medical records, including an October 31, 2000 CT-scan. He considered a sufficiently accurate account of Claimant's smoking and coal mine employment histories. Dr. Broudy opined that he could not find any evidence of radiographic progression, or any definite evidence that Claimant suffers from CWP. He opined that Claimant was massively obese, which led to underpenetration on chest x-rays and a mild restrictive defect. Dr. Broudy set forth clinical observations and findings, and his reasoning is supported by adequate data. His opinion is reasoned and documented. I find that his opinion is entitled to probative weight enhanced by his credentials as a board-certified pulmonologist.

Dr. Burki examined Claimant in 2001. He diagnosed Claimant as obese, to which he attributed Claimant's restrictive defect. He found a chest x-ray to be negative. He set forth clinical observations and findings, and his reasoning is supported by adequate data. He submitted Claimant to objective testing, considered sufficiently accurate accounts of Claimant's smoking and coal mine employment histories, noted Claimant's subjective complaints. His opinion is reasoned and documented. I find that Dr. Burki's opinion is entitled to probative weight enhanced by his credentials as a board-certified pulmonologist.

Dr. Fino opined that Claimant has simple pneumoconiosis based on his chest x-ray interpretation. However, he found no evidence of any respiratory or pulmonary impairment arising out of coal dust exposure. He reviewed Claimant's medical records and considered a sufficiently accurate account of Claimant's coal mine employment and smoking histories. Dr. Fino's diagnosis of clinical pneumoconiosis does not constitute a reasoned medical judgment because it was only based on chest x-ray interpretations. His finding that Claimant does not suffer from legal pneumoconiosis also does not constitute a reasoned medical judgment, since he did not identify any of the data upon which he relied to reach his conclusion. I find that Dr. Fino's opinions are entitled to a lesser degree of probative weight.

Dr. Dahhan issued a consultative report in October of 2001. He reviewed and summarized Claimant's medical records, including Claimant's hospital records from Dr. Yu. Based on his prior reviews and his most recent review, Dr. Dahhan again opined that there was insufficient evidence to justify a diagnosis of CWP based on clear lungs on clinical examination, negative chest x-ray interpretations, a mild reduction in ventilatory capacity, and adequate gas exchange. He noted that Claimant's asthma does not arise out of coal dust exposure. He also found no evidence of any pulmonary impairment arising out of coal dust exposure based on the entire record. Dr. Dahhan set forth clinical observations and findings, and his reasoning is supported by adequate data. His opinion is reasoned and documented. I find that Dr. Dahhan's opinion is entitled to probative weight enhanced by his credentials as a board-certified pulmonologist.

Dr. Premji answered questions posed by counsel for Claimant in December of 2002. He had been treating Claimant for COPD since of October of 1996. However, he could not answer the question of whether or not Claimant's history of 6-12 years of coal mine employment would be a significant contributing factor to Claimant's COPD and respiratory disabling conditions. Dr. Premji's diagnosis of COPD does not arise to a diagnosis of legal pneumoconiosis.

Dr. Dahhan issued another consultative opinion in 2002. After interpreting a chest x-ray from 2001 as negative for pneumoconiosis and reviewing additional medical records, he reiterated the findings and conclusions contained in his prior reports. Dr. Dahhan's reviewed the CT scan interpretations of Dr. Tiu. He indicated that Claimant's carboxyhemoglobin value from March of 2001 was consistent with an individual who smokes two packs of cigarettes per day. Again, I find that Dr. Dahhan's opinion is reasoned and documented. His opinion is entitled to probative weight enhanced by his credentials as a board-certified pulmonologist.

Claimant has been diagnosed with several conditions that affect his cardiopulmonary system, including asthma, COPD, chronic bronchitis, hypoxemia, hilar adenopathy, fine diffuse reticular interstitial processes, allergic rhinitis, obesity, clinical pneumoconiosis, legal pneumoconiosis, and occupational pneumoconiosis.

I will initially evaluate the preceding opinions that are responsive to clinical pneumoconiosis. The primary evidence supporting a finding of clinical pneumoconiosis is the CT scan interpretation of Dr. Tiu. Dr. Yu, who reviewed Dr. Tiu's CT scan interpretations and chest x-ray interpretations, opined that Claimant had clinical pneumoconiosis. Based on the quality of evidence that Dr. Tiu reviewed, the frequency of his examinations of Claimant, and his treatment attempts to control Claimant's other pulmonary symptoms, I find that Dr. Yu's opinion is entitled to substantive weight. Dr. Fino's opinion, stating that Claimant suffered from clinical pneumoconiosis, is entitled to little probative weight, but is notable because it was adduced by Employer. Several other physicians, whose opinions are entitled to little weight because they were based solely on chest x-ray interpretations also diagnosed clinical pneumoconiosis. Drs. Dahhan and Broudy both proffer contrary opinions: Dr. Broudy opined that there was no definitive evidence of clinical pneumoconiosis, while Dr. Dahhan stated that he found no objective evidence to support a finding of clinical pneumoconiosis. Their reasoned and documented opinions are both entitled to an enhanced degree of weight. In fact, both physicians summarized Dr. Tiu's October 2000 CT scan before rendering their contrary opinions. Certainly, Dr. Tiu's October 2000 CT scan is not a definitive diagnosis of clinical pneumoconiosis. However, it is objective evidence supporting a finding of an occupational pneumoconiosis. Dr. Dahhan's statement that there is no objective evidence of clinical pneumoconiosis is flatly contradicted by Dr. Tiu's CT scan interpretation. Dr. Dahhan did discuss the implications of the October 2000 CT scan. Dr. Broudy's opinion is more justifiable than Dr. Dahhan's opinion, but by only saying that there is no definitive evidence of clinical pneumoconiosis, Dr. Broudy's opinion does not foreclose a finding of clinical pneumoconiosis and it even implies that there is some degree of evidence that supports a finding of pneumoconiosis.

I find that Complainant has established the existence of clinical pneumoconiosis by a preponderance of the evidence. Dr. Tiu's October 2000 CT scan, and to a lesser degree his 1999 CT scan, provides objective evidence of an occupational pneumoconiosis. Dr. Yu, based on his clinical evaluations of Claimant and his review of Dr. Tiu's CT scans and chest x-rays, diagnosed clinical pneumoconiosis. The quality of the reasoning of the opinions of Drs. Broudy and Dahhan suffers from their choice not to evaluate the CT scan findings, which relegates their opinions to a lesser status in comparison to combined weight of the opinions of Drs. Yu and Tiu.

Several physicians have opined that Claimant suffers from legal pneumoconiosis. However, I find that the preponderance of the evidence establishes that any chronic pulmonary impairment Claimant suffers from arises out of his history of cigarette smoking, his asthma, and his obesity. Drs. Baker and Miller both diagnose legal pneumoconiosis. However, Dr. Baker merely attributes Claimant's COPD, hypoxemia, and chronic bronchitis to Claimant's history of smoking and coal dust exposure. Dr. Miller finds that Claimant's pulmonary impairment is primarily due to his coal dust exposure. Drs. Baker and Miller do not address Claimant's other symptoms, nor did they provide rationale for attributing Claimant's impairment to smoking and coal dust exposure. Drs. Broudy, Burki, Dahhan, Fino, and Paranthaman all attribute Claimant's pulmonary impairment to a combination of obesity, asthma, and Claimant's history of cigarette smoking. Their opinions are better reasoned than the opinions of Drs. Baker and Miller because they provide more supporting rationale. I find that Claimant has failed to establish, by a preponderance of the evidence, that he suffers from legal pneumoconiosis.

As I have found that Claimant established the existence of clinical pneumoconiosis, I find that he has established the existence of pneumoconiosis under subsection (a)(4). Accordingly, I find that Claimant has established the existence of pneumoconiosis.

Arising Out of Coal Mine Employment

I previously determined that Claimant has established that his pneumoconiosis arose, at least in part, out of his coal mine employment based on the newly submitted evidentiary record, which I compared to the previously submitted evidence. Therefore, I find that Claimant's pneumoconiosis arose, at least in part, out of his coal mine employment.

Total Disability

To prevail, Claimant must also demonstrate that he is totally disabled from performing his usual coal mine work or comparable work due to pneumoconiosis under one of the five standards of § 718.204(b) or the irrebuttable presumption referred to in § 718.204(b). The Board has held that under Section 718.204(b), all relevant probative evidence, both "like" and "unlike" must be weighed together, regardless of the category or type, in the determination of whether the Claimant is totally disabled. *Shedlock v.*

Bethlehem Mines Corp., 9 B.L.R. 1-195 (1986); *Rafferty v. Jones & Laughlin Steel Corp.*, 9 B.L.R. 1-231 (1987). Claimant must establish this element of entitlement by a preponderance of the evidence. *Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-4 (1986).

Claimant did not adduce any evidence to establish that he suffers from complicated pneumoconiosis. I find that Claimant has not established the existence of complicated pneumoconiosis. Therefore, the irrebuttable presumption of § 718.304 does not apply.

Total disability can be shown under § 718.204(b)(2)(i) if the results of pulmonary function studies are equal to or below the values listed in the regulatory tables found at Appendix B to Part 718. None of the five newly submitted PFTs, nor any of the PFTs previously submitted produced qualifying values. Therefore, I find that Claimant has not established total disability under subsection (b)(2)(i).

Total disability can be demonstrated under § 718.204(b)(2)(ii) by the results of arterial blood gas studies. Claimant did not adduce any ABG that produced a qualifying value. Therefore, I find that Claimant has not established total disability under subsection (b)(2)(ii).

Total disability may also be shown under § 718.204(b)(2)(iii) if the medical evidence indicates that Claimant suffers from cor pulmonale with right-sided congestive heart failure. There was no evidence of cor pulmonale with right-sided congestive heart failure to consider. Therefore, I find that Claimant has not established total disability under subsection (b)(2)(iii).

Section 718.204(b)(2)(iv) provides for a finding of total disability if a physician, exercising reasoned medical judgment based on medically acceptable clinical or laboratory diagnostic techniques, concludes that Miner's respiratory or pulmonary condition prevented Miner from engaging in his usual coal mine employment or comparable gainful employment.

The exertional requirements of the claimant's usual coal mine employment must be compared with a physician's assessment of the claimant's respiratory impairment. *Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6th Cir. 2000). Once it is demonstrated that the miner is unable to perform his usual coal mine work, a *prima facie* finding of total disability is made and the party opposing entitlement bears the burden of going forth with evidence to demonstrate that the miner is able to perform "comparable and gainful work" pursuant to § 718.204(b)(1). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988). Nonrespiratory and nonpulmonary impairments have no bearing on establishing total disability due to pneumoconiosis. § 718.204(a); *Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241 (1994). All evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing by a preponderance of the evidence the existence of this element. *Mazgaj v. Valley Camp Coal Co.*, 9 B.L.R. 1-201 (1986). Claimant's was initially employed as an underground miner who worked at the face. However, his last coal mine employment was as a tipple

operator, where he was occasionally required to operate equipment, shovel coal, and lift parts to repair the tipple.

After examining Claimant in November of 2000, Dr. Baker found that Claimant retained the respiratory capacity to perform the work of a coal miner or comparable gainful work in a dust-free environment. He concluded that Claimant only suffered from a mild pulmonary impairment based on his decreased FEV1, bronchitis, decreased pO2, and CWP. Dr. Baker submitted Claimant to objective testing, noted Claimant's subjective complaints, and considered a sufficiently accurate account of Claimant's coal mine employment and smoking histories. He set forth clinical observations and findings, and his reasoning is supported by adequate data. His opinion is reasoned and documented. I find that Dr. Baker's opinion is entitled to probative weight enhanced by his credentials as a board-certified pulmonologist.

Dr. Miller examined Claimant a month after Dr. Baker in 2000, and opined that Claimant was totally and permanently disabled by a pulmonary impairment in the form of CWP. He noted that Claimant's FEV1 values was less than 55% of the predicted value. He considered Claimant's history, symptoms, and his physical examination. He recorded a sufficiently accurate account of Claimant's smoking and coal mine employment histories. Dr. Miller set forth clinical observations and findings, and his reasoning is supported by adequate data. His opinion is reasoned and documented. I find that Dr. Miller's opinion is entitled to probative weight enhanced by his board-certification in internal medicine.

Dr. Paranthaman examined Claimant in March of 2001. He opined that Claimant had a mild pulmonary impairment, adding that Claimant retains the respiratory capacity to do the job of a coal miner. He found that Claimant had mild hypoxemia at rest based on an ABG. He conducted a PFT, which he invalidated due to suboptimal effort, but he noted that Claimant's values had not changed from his prior PFTs. Dr. Paranthaman submitted Claimant to objective testing, noted his subjective complaints, and considered a sufficiently accurate account of Claimant's smoking and coal mine employment histories. He set forth clinical observations and findings, and his reasoning is supported by adequate data. His opinion is reasoned and documented. I find that Dr. Paranthaman's opinion is entitled to probative weight enhanced by his credentials as a board-certified pulmonologist.

Dr. Dahhan also examined Claimant in March of 2001. He found that Claimant had a mild respiratory impairment due to his excessive obesity, but that there was no evidence of total or permanent disability. Dr. Dahhan found that Claimant's spirometry and blood gas exchange were normal. He submitted Claimant to objective testing, noted his subjective complaints, and considered a sufficiently accurate account of Claimant's smoking and coal mine employment histories. He set forth clinical observations and findings, and his reasoning is supported by adequate data. His opinion is reasoned and documented. I find that Dr. Dahhan's opinion is entitled to probative weight enhanced by his credentials as a board-certified pulmonologist.

Dr. Broudy provided a consultative report in April of 2001. He stated, since Claimant provided varying effort on his PFTs, at most claimant has a mild impairment. Dr. Broudy concluded that Claimant is not totally disabled due to any cause. He reviewed and summarized Claimant's medical records. He set forth clinical observations and findings, and his reasoning is supported by adequate data. His opinion is reasoned and documented. I find that Dr. Broudy's opinion is entitled to probative weight enhanced by his credentials as a board-certified pulmonologist.

Dr. Burki examined Claimant in April of 2001 and found him to be suffering from an unclassified restrictive defect due to obesity. He submitted Claimant to objective testing, noted his subjective complaints, and considered a sufficiently accurate account of Claimant's smoking and coal mine employment histories. Dr. Burki set forth clinical observations and findings, and his reasoning is supported by adequate data. His opinion is reasoned and documented. I find that Dr. Burki's opinion is entitled to probative weight enhanced by his credentials as a board-certified pulmonologist.

Dr. Fino provided a consultative opinion in May of 2001. He found no evidence of any respiratory or pulmonary impairment. He commented that the PFT performed by Dr. Paranthaman does not represent Claimant's true lung functioning because Claimant provided poor effort. Dr. Fino reviewed and summarized Claimant's medical records. He set forth clinical observations and findings, but he provided precious little reasoning to support his conclusions. While I find his opinion to be reasoned and documented, I attribute less weight to his opinion due to the absence of supporting rationale.

After examining Claimant's medical records in October of 2001, Dr. Dahhan issued a consultative report finding that Claimant was not totally and permanently disabled based on his review of Claimant's clinical and physiological parameters. He found that Claimant displayed a mild reduction in ventilatory capacity, but that Claimant had adequate gas exchange. He also found that Claimant had mild asthma. Dr. Dahhan reviewed and summarized Claimant's medical records, and he considered a sufficiently accurate account of Claimant's smoking and coal mine employment histories. He set forth clinical observations and findings, and his reasoning is supported by adequate data. His opinion is reasoned and documented. I find that Dr. Dahhan's opinion is entitled to probative weight enhanced by his credentials as a board-certified pulmonologist.

After reviewing even more medical records, Dr. Dahhan issued another consultative opinion in July of 2002. He concluded, from a functional standpoint, that Claimant has no evidence of a pulmonary disability. He found that Claimant retained the respiratory capacity to perform his previous coal mine employment or a job of comparable physical demand. Dr. Dahhan's opinions were based on the physiological parameters of Claimant's respiratory system. While Dr. Dahhan did not provide the same kind of supporting rationale as his prior opinions did, I find that Dr. Dahhan's opinion is reasoned and documented. His opinion is entitled to probative weight enhanced by his credentials as a board-certified pulmonologist.

Claimant was forty-four years-old at the time of the hearing. His prior coal mine employment as a tipple operator required him to sit for one-to-two hours per day, stand for six-to-seven hours per day, and to lift twenty-to-thirty pounds four or five times per day. Claimant's previous coal mine employment requires mild to moderate amount of effort. The evidence overwhelmingly establishes that Claimant suffers from a mild respiratory impairment. Aside from Dr. Premji's assessment that Claimant suffers from moderate COPD, the remaining physicians find that Claimant's pulmonary impairment is mild. Despite his mild impairment, I find that Claimant retains the respiratory capacity to perform his previous coal mine employment. Drs. Baker, Burki, Broudy, Dahhan, Fino, and Paranthaman all opined that Claimant retained the respiratory capacity to perform his previous coal mine employment. And, with the exception of Dr. Fino, all of these physicians found that Claimant suffered from a mild pulmonary impairment. Drs. Yu did not address Claimant's level of pulmonary impairment. Claimant is relatively young, his prior coal mine employment did not require heavy manual labor, and he only suffers from a mild respiratory impairment. Therefore, I find that Claimant has not established total disability under subsection (b)(2)(iv).

Claimant has failed to establish total disability under any applicable subsection of § 718.204(b). Therefore, I find that Claimant is not totally disabled due to a respiratory or pulmonary impairment.

Total Disability Due to Pneumoconiosis

Assuming *arguendo* that Claimant established the existence of a totally disabling respiratory or pulmonary impairment, I will analyze the record to determine if Claimant's respiratory or pulmonary impairment was due to pneumoconiosis. The amended regulations at § 718.204(c) contain the standard for determining whether Miner's total disability was caused by Miner's pneumoconiosis. Section 718.204(c)(1) determines that a miner is totally disabled due to pneumoconiosis if pneumoconiosis, as defined in § 718.201, is a "substantially contributing cause" of the miner's totally disabling respiratory or pulmonary impairment. Pneumoconiosis is a "substantially contributing cause" of the miner's disability if it has a material adverse effect on the miner's respiratory or pulmonary condition or if it materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment. §§ 718.204(c)(1)(i) and (ii). Section 718.204(c)(2) states that, except as provided in § 718.305 and § 718.204(b)(2)(iii), proof that the Miner suffered from a totally disabling respiratory or pulmonary impairment as defined by §§ 718.204(b)(2)(i), (ii), (iv), and (d) shall not, by itself, be sufficient to establish that the miner's impairment was due to pneumoconiosis.

Except as provided by § 718.204(d), the cause or causes of a miner's total disability shall be established by means of a physician's documented and reasoned medical report. § 718.204(c)(2). The Sixth Circuit Court of Appeals has stated that pneumoconiosis must be more than a "de minimus or infinitesimal contribution" to the miner's total disability. *Peabody Coal Co. v. Smith*, 12 F. 3d 504, 506-507 (6th Cir. 1997). The Sixth Circuit has also held that a claimant must affirmatively establish only

that his totally disabling respiratory impairment (as found under § 718.204) was due 'at least in part' to his pneumoconiosis. *Cf.* 20 C.F.R. 718.203(a)." *Adams v. Director, OWCP*, 886 F.2d 818, 825 (6th Cir. 1988); *Cross Mountain Coal Co. v. Ward*, 93 F.3d 211, 218 (6th Cir. 1996)(opinion that miner's "impairment is due to his combined dust exposure, coal workers' pneumoconiosis as well as his cigarette smoking history" is sufficient). More recently, in interpreting the amended provision at § 718.204(c), the Sixth Circuit determined that entitlement is not precluded by "the mere fact that a non-coal dust related respiratory disease would have left the miner totally disabled even without exposure to coal dust." *Tennessee Consolidated Coal Co. v. Director, OWCP [Kirk}*, 264 F.3d 602 (6th Cir. 2001). A miner "may nonetheless possess a compensable injury if his pneumoconiosis materially worsens this condition." *Id*.

The reasoned medical opinions of those physicians who diagnosed the existence of pneumoconiosis and that Miner was totally disabled are more reliable for assessing the etiology of Miner's total disability. *See, e.g. Hobbs v. Clinchfield Coal Co.*, 45 F.3d 819 (4th Cir. 1995); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109 (4th Cir. 1995). For the purposes of analyzing whether opinions rendered on the issues of the existence of CWP and total disability, I considered the opinions of physicians who relied on Claimant's statement that he worked twelve years in coal mine employment to be sufficiently accurate. However, the inconsistency between the statements from Claimant that physicians relied upon and what the record establishes, must be taken into consideration when ultimately determining whether Claimant's total disability was due to pneumoconiosis arising out of coal mine employment.

Claimant suffers from CWP, chronic bronchitis, asthma, hypoxemia, and obesity. I have determined that he has a smoking history of one pack per day for twenty years; there is also some credible evidence that Claimant smoked longer than twenty years. I have also determined that Claimant established six years of coal mine employment. Dr. Miller is the only physician who found Claimant to have been totally disabled due to pneumoconiosis. Dr. Miller relied on a chest x-ray he reviewed and a PFT he conducted to find that Claimant was totally and permanently disabled due to CWP. The PFT that Dr. Miller conducted did not produce values that qualify for total disability, but he cited to Claimant's FEV1 values that was less than 55% of predicted. He also considered a coal mine employment history of twelve years, which is six more years than I have credited Claimant as having worked. Dr. Miller stated that Claimant's occupational exposure to coal dust was the primary contributing factor to Claimant's totally disabling lung condition. However, Dr. Miller does not address the effects, if any, that Claimant's smoking history, asthma, and obesity have on creating Claimant's disability. Dr. Baker also found that Claimant's pulmonary impairment was due to cigarette smoking and coal dust exposure. However, similar to Dr. Miller's opinion, he did not address Claimant's chronic bronchitis, obesity, and asthma. Moreover, Dr. Baker found that Claimant was not totally disabled, which reduces the reliability of his opinion. Dr. Premji declined to address the question of whether Claimant's 6-12 years of coal mine employment were a significant contributing factor to his total disability.

Dr. Paranthaman provided the most detailed analysis of the etiology of Claimant's pulmonary impairment. He diagnosed the existence of pneumoconiosis. However, based on his review of an EKG and ABG that he conducted, Dr. Paranthaman attributed Claimant's pulmonary impairment to Claimant's obesity because Claimant showed improvement on his ABGs after undergoing exercise. Drs. Broudy, Burki, Dahhan, and Fino attribute Claimant's pulmonary impairment to cigarette smoking and obesity. Assuming, arguendo, that Claimant established the existence of a totally disabling respiratory impairment, I find that that there is insufficient evidence to establish that it was due, at least in part, to pneumoconiosis arising out of coal mine employment. Rather, I find that Claimant's pulmonary impairment was caused by a combination of asthma, cigarette smoking, and obesity.

Entitlement

The Claimant, Roy Farmer, has failed to prove, by a preponderance of the evidence, that he is totally disabled due pneumoconiosis arising out of coal mine employment. Therefore, Mr. Farmer is not entitled to benefits under the Act.

Attorney's Fees

An award of attorney's fees is permitted only in cases in which the claimant is found to be entitled to benefits under the Act. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for the representation and services rendered in pursuit of the claim.

ORDER

IT IS ORDERED that the claim of Roy Farmer for benefits under the Act is hereby DENIED.

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THOMAS F. PHALEN, JR.
Administrative Law Judge

NOTICE OF APPEAL RIGHTS

Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date of this decision, by filing notice of appeal with the Benefits Review Board, P.O. Box 37601, Washington, D.C. 20013- 7601. **A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, D.C.**